



Harvard Medical Alumni Bulletin

September/October 1976

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Harvard Medical Alumni Bulletin

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Cover: Our cover is for passers-by who may have seldom noticed the striking perspective that faces them as they approach the upper steps to Building A, and for those who have often appreciated the handsome architectural juxtaposition. In this composition, the two spires of Mission Church fall between the Kresge Building of the School of Public Health (to the left) and the broad side of the Countway Library (on the right). Mission Hill Church was built in 1871 on Tremont Street. In 1954 Pope Pious XII conferred upon it the special title of Basilica of Our Lady of Perpetual Help, making the church one of only four basilicas in the United States.

Credits: Cover, p. 9, David Gunner; p. 12, 15, courtesy of Mrs. Frank Wigglesworth; p. 19, courtesy of Charles B. Huggins; p. 19 (bottom), 1924 *Aesculapiad*; p. 20, 1931 *Aesculapiad*; p. 25, Fig. 4, reproduced with permission from *Gastroenterology*, August 1974. Copyright © by the Williams & Wilkins Co., Baltimore; Fig. 5, reproduced with permission from *Patient Care*, October 15, 1974. Copyright © by Miller and Fink Corporation, Darien, Connecticut; p. 27, 28, Alice Webber; p. 40, Yousuf Karsh Collection, Countway Library; p. 42, courtesy of American Elsevier Publishing Company; p. 43, courtesy of Albert I. Mendeloff '42.

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Overview

HMSer on scholarship at Oxford

Perry J. Blackshear, HMS III, a former Rhodes Scholar recognized for his research in diabetes and surgery, was awarded an International College of Surgeons Undergraduate Scholarship in July. The award covers a period of study at two hospitals associated with Oxford University Medical School, Oxford, England: in August Mr. Blackshear studied orthopedic surgery at the Nuffield Orthopaedic Center in Oxford under the guidance of Professor Duthie, and during September and October he is pursuing obstetrics and gynecology at the new John Radcliffe Hospital in Oxford under the direction of Professor Turnbull.

In 1969, Mr. Blackshear gained worldwide prominence for the invention of his Implantable Infusion Pump at the University of Minnesota — an implantable, self-recycling, infusion pump of simple design to be used in device applications for continuous heparin anticoagulation, artificial pancreas, insulin infusion, chemotherapeutic organ perfusion and regional vasodilation. He has authored and co-authored many articles in American medical journals, and has given research presentations to medical, surgical and diabetes associations in the US, England and Europe. In 1971-74 he did postgraduate work in biochemistry at Trinity College, Oxford University.

1976-77 film series debuts

"Leaders in American Medicine," a film and discussion series held Wednesday afternoons at the Countway Library and open to the public, focuses on the lives and achievements of five distinguished physicians this year. The program is sponsored by the medical schools of Brown, Tufts and Boston universities, the Benjamin Waterhouse Medical History Society, and the Boston Medical Library, and is under the chairmanship of G. E. Gifford, Jr., M.D., who is associate professor of socio-medical sciences at Boston University School of Medicine, consultant to the historical collections at the Countway, and secretary of the board of trustees of the Boston Medical Library. The following features are scheduled:

Franz J. Ingelfinger '36, editor of the *New England Journal of Medicine*, October 13, 1976. Discussants: Thomas C. Chalmers, M.D., president and dean of Mt. Sinai School of Medicine; Lester S. King '32, senior editor, *Journal of the American Medical Association*; Franz J. Ingelfinger, M.D.

Martin M. Cummings, M.D., director of The National Library of Medicine, November 17, 1976. Discussants: Douglas W. Bryant, librarian, Harvard University; Ching-chih Chen, Ph.D., associate professor of library science and acting assistant dean, Simmons College; Martin M. Cummings, M.D.

Elliott P. Joslin, M.D., late founder of the Joslin Clinic, February 9, 1977. Discussants: Charles H. Best, M.D., co-discoverer of insulin and professor of physiology, emeritus, University of Toronto; Alexander Marble '27, professor of medicine, emeritus, HMS; George F. Cahill, Jr., M.D., professor of medicine, HMS and director of the Elliott P. Joslin Research Laboratory.

Walsh McDermott, M.D., professor of public affairs in medicine, Cornell University College of Medicine, March 9, 1977. Discussants: David E. Rogers, M.D., president of The Robert Wood Johnson Foundation; John I. Sandson, M.D., dean, Boston University School of Medicine; Walsh McDermott, M.D.

George W. Thorn, M.D., Hersey Professor of Medicine, emeritus, HMS, April 13, 1977. Discussants: John P. Merrill '42, professor of medicine, HMS and director of the renal division, Peter Bent Brigham Hospital; John Z. Bowers, M.D., president, Josiah Macy, Jr. Foundation and president of Alpha Omega Alpha; George W. Thorn, M.D.

Refreshments served at 4:00 P.M. will precede the programs, which will start at 4:30. Four of the films were produced by Alpha Omega Alpha and the National Library of Medicine as part of a series, *Leaders in American Medicine, the Autobiographical Memoirs of Eminent Medical Scientists and Teachers*. The film to be shown on February 9, "Diabetes in Youth," introduced and concluded by the late Elliott P. Joslin, M.D., is distributed by the Audio-Visual Utilization Center at Wayne State University, Detroit, Michigan. The series of programs at the Countway is made possible by a grant from the Josiah Macy, Jr. Foundation to the section on the history of medicine at the Boston University School of Medicine.

Emeriti faculty named

Six retiring members of the faculty of medicine have been honored with emeritus status by the President and Fellows of Harvard College this summer. The new emeriti are:

Lewis Dexter '36, professor of medicine at the Peter Bent Brigham Hospital, emeritus;

Jack R. Ewalt, M.D., the Bullard Professor of Psychiatry, emeritus;

Daniel H. Funkenstein, M.D., professor of psychiatry at the Massachusetts Mental Health Center, emeritus;

Elvin V. Semrad, M.D., professor of psychiatry, emeritus;

William H. Sweet '36, professor of surgery, emeritus; and

Nathan B. Talbot '36, the Charles Wilder Professor of Pediatrics, emeritus.

HSPH program clarifies health care maze

Harvard once again will be offering the Executive Program in Health Policy, Planning and Regulation, which is given under the auspices of the Executive Programs in Health Policy and Management. The month-long program will run from February 27 through March 25, 1977 at the School of Public Health.

The program's content is oriented towards health professionals who hold senior positions in such agencies as health systems agencies, state health departments, Medicaid programs, professional standards review organizations and rate setting bodies. Senior individuals from appropriate federal agencies, state legislative committees, private companies and health care institutions are also encouraged to apply.

To develop both analytical skills and substantive knowledge of the health care system, an intensive and carefully designed sequence of sessions will employ a variety of instructional formats, including both lectures and case discussions. Emphasis will be placed on the political economy of the health system, on the use of statistical data, decision theory and cost-benefit analysis, and on the use of organizational analysis. Among the substantive and administrative problems to be covered are quality of care regulation, certificate of need procedures, mechanisms for controlling hospital costs and prices, manpower planning, enforcement and inspection techniques, legal constraints and initiatives, and the impact of community and political pressures on the regulatory process.

As a matter of policy, Harvard does not discriminate in the admission or treatment of participants on the basis of race or sex. Executive Programs strongly encourages applications from minorities and women. For further information contact: Administrative Director for Policy Programs, Executive Programs in Health Policy and Management, Harvard School of Public Health, 677 Huntington Avenue, Boston, Massachusetts 02115, (617)734-3300, ext. 2601.

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and **George J. Annas**
Boston University Schools of Law
and Medicine

Focusing on recent events that have compelled the U.S. Congress and courts to confront the legal problems posed by applied human genetics, internationally renowned scientists, physicians, lawyers, and ethicists explore such controversial issues as: the legal rights of the fetus, prenatal diagnosis of hereditary disorders, genetic counseling and screening, *in vitro* fertilization and cloning, eugenic sterilization, the XYY controversy, and nontreatment of the genetically defective newborn. *532 pages, \$22.50*

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PROMOTIONS

Professor

Kurt J. Bloch: medicine at the Massachusetts General Hospital

Harvey Goldman: pathology at the Beth Israel Hospital

Norman K. Hollenberg: radiology

Elliot G. Mishler: social psychology in the department of psychiatry at the Massachusetts Mental Health Center

Jerry S. Trier: medicine

Associate Professor with Tenure

Nicholas Zervas: surgery

Associate Professor

Elliott Alpert: medicine at the MGH

David S. Auld: biological chemistry

Eliot L. Berson '62: ophthalmology

Robert S. Blacklow '59: medicine at the Peter Bent Brigham Hospital

Mortimer J. Buckley: surgery at the MGH
 Harvey I. Cantor: medicine
 Verne S. Caviness, Jr. '62: neurology at the MGH
 Stafford I. Cohen: medicine at the BIH
 Peter F. Cohn: medicine at the PBBH
 Willird M. Daggett: surgery at the MGH
 Robert C. Ellison: pediatrics at the Children's Hospital
 Medical Center
 Freddy H. Frankl: psychiatry at the BIH
 Richard J. Grand: pediatrics
 Jon E. Gudeman '63: psychiatry at the MGH
 Harley A. Haynes '63: dermatology at the PBBH
 Elizabeth T. Hedley-Whyte: neuropathology at the CHMC
 Martin S. Hirsch: medicine at the MGH
 B. Leonard Holman: radiology at the PBBH
 Adolph M. Hutter, Jr.: medicine at the MGH
 David J. Ingle: psychology in the department of psychiatry
 Norval W. King, Jr.: comparative pathology at the New
 England Regional Primate Research Center
 Dieter Koch-Weser: preventive and social medicine at the
 Harvard Medical School
 Edwin H. Kolodny: neurology at the MGH
 Ruth B. Kundsinn: microbiology and molecular genetics at the
 PBBH
 Martin J. Kushmerick: physiology
 Robert C. Leinbach '61: medicine at the MGH
 Harvey L. Levy: neurology at the MGH
 David M. Livingston: medicine
 Chiam I. Mayman: neurology at the BIH
 Keith W. Miller: pharmacology
 Carol C. Nadelson: psychiatry at the BIH
 Henry P. Paulus: biological chemistry
 John P. Remensnyder '57: surgery at the MGH
 Stanley J. Robboy: pathology at the MGH
 D. Rao Sanadi: biological chemistry
 Vivian E-An Shih: neurology at the MGH
 John J. Skillman: surgery at the BIH
 Arnold L. Smith: pediatrics
 Gene M. Smith: psychology in the departments of anesthesia
 and psychiatry at the MGH
 S. Robert Snodgrass '63: neurology
 Frank E. Speizer: medicine at the PBBH
 Salvador Treves: radiology at the CHMC
 Dan Tulchinsky: obstetrics and gynecology at the Boston
 Hospital for Women
 Manjeri A. Venkatachalam: pathology
 Jack Wittenberg: radiology at the MGH

Associate Clinical Professor

S. Arthur Boruchoff: ophthalmology
 Robert J. Brockhurst '47: ophthalmology
 Anna-Marie Gron: orthodontics
 Poul Gron: oral biology and pathophysiology
 Alvin A. Krakow: endodontics
 William W. Meissner: psychiatry
 Arnold H. Modell: psychiatry
 Edward A. Nalebuff: orthopedic surgery
 Bennett Simon: psychiatry
 Sigmund S. Socransky: oral biology
 Richard F. Spark: medicine
 William H. Timberlake: neurology

Assistant Professor

Lloyd M. Aiello: ophthalmology
 Joseph S. Alpert '69: medicine at the PBBH
 Thomas T. Aoki: medicine
 Lloyd Axelrod '67: medicine
 Roger A. Bauman: radiology at the MGH
 Don C. Bienfang '65: ophthalmology
 Jason C. Birnholz: radiology
 William D. Bloomer: radiation therapy
 Lenore A. Boling: psychiatry at the McLean Hospital
 Walter U. Brown, Jr.: anesthesiology
 James A. Burton: pathology
 Frank P. Castronovo: radiology
 Gerson Cohen: prosthetic dentistry at the Brockton Veterans
 Administration Hospital
 Doris Dahl: neuropathology
 Kenneth R. Davis: radiology at the MGH
 G. Robert DeLong '61: neurology at the MGH
 Donald R. Dibona: physiology in the department of medicine
 G. Richard Dickersin: pathology at the MGH
 Frank H. Duffy '63: neurology at the CHMC
 Carlotta A. Koziol Evans: orthodontics
 Nabil R. Fahmy: anesthesia at the MGH
 Kenneth R. Falchuk: medicine at the PBBH
 Douglas T. Fearon: medicine
 Daniel A. Garcia: oral diagnosis and oral radiology at the
 West Roxbury Veterans Administration Hospital
 Raif S. Geha: pediatrics
 Michael A. Gimbrone, Jr. '69: pathology
 Thomas H. Glick '66: neurology at the Cambridge Hospital
 Nishan G. Goudsouzian: anesthesia at the MGH
 Ferris M. Hall: radiology
 Stephen V. Hall '69: anesthesia at the BIH
 Mary E. Hale Hammond: pathology
 Judith Herzfeld: biophysics
 Samuel J. Hessel: radiology
 James E. House: prosthetic dentistry at the Boston Veterans
 Administration Outpatient Clinic
 John R. Hoyer '64: pediatrics
 Newton E. Hyslop, Jr. '61: medicine at the MGH
 Lee B. Jacoby: pediatrics (genetics)
 Philip F. Judy: radiology
 William D. Kaplan: radiology
 Kenneth Kase: radiation therapy
 Peter K. Kijewski: radiation therapy
 Michael Klagsbrun: surgery (biochemistry)
 Ione A. Kourides '67: medicine at the MGH
 James R. Lehigh '62: neurology at the MGH
 Rudolph L. Leibel: pediatrics at the MGH
 John C. Long: pathology
 Ira T. Lott: neurology at the MGH
 Edward R. McFadden, Jr.: medicine at the PBBH
 Michael A. Moskowitz: neurology
 Richard J. Mullen: neuropathology
 Marian R. Neutra: anatomy
 Eli H. Newberger: pediatrics
 Gerard W. Ostheimer: anesthesia
 Lynn M. Peterson: surgery
 Ernest H. Picard '55: neurology at the MGH
 Eliezer Rapaport: medicine (biochemistry)
 Randi V. Rosvoll: pathology at the New England Deaconess
 Hospital
 Maria Z. Salam: neurology at the MGH

Stephen E. Sallan: pediatrics at the CHMC
 Albert J. Saubermann: anesthesia at the BIH
 Edward B. Seldin '68: oral surgery
 Franklin A. Sher: pathology
 Samuel J. Shubrooks, Jr.: medicine
 Jacob B. Silversin: dental ecology
 Michael T. Snider: anesthesia at the MGH
 Richard S. Surwit: psychology in the department of psychiatry
 Anthony T. Tolentino: prosthetic dentistry
 Jack R. Wands: medicine
 Stephen I. Wasserman: medicine
 Roy S. Weiner: medicine at the Sidney Farber Cancer Center
 Barbara N. Weissman: radiology
 Robert M. Williams '74: medicine
 Roberta G. Williams: pediatrics

Assistant Clinical Professor

Merle J. Berger: obstetrics and gynecology
 Charles K. Beyer: ophthalmology
 John R. Blitzler '48: psychiatry
 Dick A. J. Brown: obstetrics and gynecology
 Sylvan L. Campbell: obstetrics and gynecology
 Melvin E. Clouse: radiology
 Dean Crocker: anesthesia
 William R. Dorsey: pediatrics
 Edward K. Dunham: medicine
 T. Corwin Fleming '56: neurology
 James L. Fozard: psychology in the department of psychiatry
 Richard Galdston '51: psychiatry
 John P. Hubbell, Jr. '43B: pediatrics
 M. Edward Keenan: pediatrics
 Francis E. Khouw: orthodontics
 Thomas Leavitt, Jr.: obstetrics and gynecology
 Alexander S. MacDonald, Jr.: pediatrics
 Frederick Mandell: pediatrics
 William F. McCourt: psychiatry
 Robert D. Mehlman '55: psychiatry
 Jacob Mezer: obstetrics and gynecology
 Lucy F. Parisi-Buckley: pediatrics
 Julian L. Pearlman: pediatrics
 Maxwell G. Potter: psychiatry
 Robert C. Reid '51: psychiatry
 Nancy Rollins: psychiatry
 Leonard E. Safon: obstetrics and gynecology
 Elliot L. Sagall '43A: medicine
 S. Patric Scavotto: oral diagnosis and oral radiology
 Jules R. Schwaber: medicine
 Felipe I. Tolentino, Jr.: ophthalmology
 Joseph S. Wallace: obstetrics and gynecology
 Ernest A. Weymuller, Jr. '66: otolaryngology
 Leroy S. Wirthlin '62: surgery

Principal Associate

Alun G. Jones: radiology (nuclear medicine)

Principal Research Associate

Karl E. Astrom: neuropathology
 Gopal M. Bhatnagar: dermatology (biochemistry)
 David A. Chesler: radiology (physics)
 Ursula C. Drager: neurobiology
 David B. Drath: biological chemistry
 Eric Frank: neurobiology
 Henry T. Keutmann '63: medicine (biochemistry)
 James Chien-Chung Li: microbiology and molecular genetics
 Roger W. Melvold: radiation biology (genetics)
 Doju Yoshikami: neurobiology

Lecturer

Aziza H. Soliman-Fam: anatomy
 Betsey S. Williams: anatomy

APPOINTMENTS

Professor

Daniel M. Albert: ophthalmic pathology
 Barry M. Brenner: medicine, to head the Laboratory of Kidney and Electrolyte Physiology of the Renal Division in the Department of Medicine at the PBBH

Associate Professor

Yves Borel: pediatrics at the CHMC
 Ambrose McLaughlin, III '65: surgery at the PBBH

Associate Clinical Professor

Harold V. Jordan: oral biology and pathophysiology
 Johannes Van Houte: oral biology and pathophysiology

Assistant Professor

R. Wayne Alexander: medicine
 Robert G. Apsler: psychology in the department of psychiatry at the CH
 Mark D. Aronson: medicine at the BIH
 Marlene A. Benson: pediatrics
 Peter J. Biggs: radiation therapy (radiation biophysics) at the MGH
 Andrew G. Braun: radiation therapy
 David R. Evans: surgery (biochemistry)
 Peter J. Quesenberry: medicine at the PBBH
 Joan Van Derveer Ruderman: anatomy
 Jonathan Shay: pathology
 Lynn J. Verhey: radiation therapy (radiation biophysics) at the MGH

Assistant Clinical Professor

Bruce R. Bistran: medicine
 Donald I. Hay: oral biology and pathophysiology
 Martin A. Taubman: oral biology and pathophysiology

Class of 1980

- Aaronson, Scott T.
Jamaica, N.Y. (Columbia)
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Somers, Conn. (Harvard)
- Aguayo, James B.
Cudahy, Wisc. (Stanford)
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River Forest, Ill. (Princeton)
- Anderson, Hilda H.
Tuskegee, Ala. (Stanford)
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Carteret, N.J. (Univ. of Pennsylvania)
- * Baron, Margaret H.
Merrick, N.Y. (Radcliffe)
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Chelsea, Mass. (Univ. of Massachusetts)
- Berlin, Robin D.
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New York, N.Y. (Yale)
- Bloom, Richard J.
Worcester, Mass. (Univ. of Massachusetts)
- Bookman, Michael A.
Braintree, Mass. (M.I.T.)
- Brill, David M.
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Kowloon, Hong Kong (Northwestern)
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Brookline, Mass. (Harvard)
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Santa Ana, Calif. (Univ. of California, Irvine)
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Lynn, Mass. (Radcliffe)

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- Kohen, Jeffrey A.
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Newton, Mass. (Boston Univ.)
- LeClaire, Jerry E.
Oshkosh, Wisc. (Harvard)
- Lee, Betty
San Francisco, Calif. (Univ. of California, Berkeley)
- Levine, Jeremiah J.
Monsey, N.Y. (Yeshiva Univ.)
- Lizambri, Richard G.
New Castle, Penn. (California Inst. of Tech.)
- Loock, Christine A.
Fort Worth, Tx. (Southern Methodist)
- Louie, Alan K.
Chicago, Ill. (Harvard)
- Low, David W.
West Hartford, Conn. (Harvard)
- Lund, Dennis P.
Duluth, Minn. (Harvard)
- Lyons, Linda
Napa, Calif. (Univ. of California, Berkeley)
- Ma, Lawrence
Durban, Natal, South Africa (Stanford)
- * Madsen, Joseph R.
Salt Lake City, Ut. (Univ. of Utah)
- Magonet, Gordon M.
St. Laurent, P.Q., Canada (M.I.T.)
- Maller, Eric S.
Laurelton, N.Y. (Harvard)
- * Mansfield, Ann B.
North Bellmore, N.Y. (M.I.T.)
- Marks, Andrew R.
New York, N.Y. (Amherst)
- Marsh, James S.
West Hartford, Conn. (Trinity)
- McGregor, Carlton C.
New York, N.Y. (Fordham)
- McKinley, Lynn J.
New York, N.Y. (Colby)
- Merab, Jacques P.
Beirut, Lebanon (M.I.T.)
- * Mercado, Anthony D.
Yonkers, N.Y. (Manhattan)
- Milch, David M.
Lawrence, N.Y. (Stanford)
- Mohammed, Zeba A.
Washington, D.C. (Bryn Mawr)
- Moneta, Gregory L.
Ontario, Calif. (Claremont Men's Coll.)
- * Moskowitz, David W.
Scarsdale, N.Y. (Harvard)
- Nelson, Richard S.
Berkeley, Calif. (Harvard)
- Pawl, Gary A.
Brookfield, Wisc. (Stanford)
- Perkins, Stanley W.
Long Beach, Calif. (Univ. of California, San Diego)
- Petersmeyer, Nancy Q.
Bronxville, N.Y. (Yale)
- Petkevich, John M.
Great Falls, Mont. (Harvard)
- Petri, Michelle A.
McLean, Va. (Radcliffe)
- Petrofes, Michelle
Tipp City, Oh. (M.I.T.)
- * Pettiford, Herman W., Jr.
Highland Park, Mich. (M.I.T.)
- Plaus, William J.
Burnt Hills, N.Y. (Union Coll.)
- Powe, Neil R.
Philadelphia, Penn. (Princeton)
- Powell, Tyrone
Los Angeles, Calif. (Stanford)
- * Redner, Robert L.
Brooklyn, N.Y. (Yale)
- Richards, Ruth L.
Trinidad, Calif. (Stanford)
- Rocco, Thomas P.
Lindenhurst, N.Y. (Cornell)
- Rodriguez, Raul M.
El Paso, Tx. (Univ. of Texas, El Paso)
- Sadler, William T.
Magna, Ut. (Univ. of Utah)
- Santini, Diana L.
New York, N.Y. (Barnard)
- * Schnitzer, Jay J.
Longmeadow, Mass. (Worcester Polytechnic Inst.)
- * Sell, Jeffrey E.
Pittsburgh, Penn. (Yale)
- Siebens, Hilary C.
Princeton, N.J. (Yale)
- Silen, Mark L.
Weston, Mass. (Univ. of Pennsylvania)
- Simmons, Charles F., Jr.
Lincoln, Neb. (Univ. of Nebraska, Lincoln)
- Simonton, Charles A., 3d
Lumberton, N.C. (Univ. of North Carolina)
- Skettino, Sandra L.
Scranton, Penn. (Wellesley)
- Slezak, Sheri
Seattle, Wash. (Univ. of Washington)
- * Smith, Barbara L.
Auburn, N.Y. (M.I.T.)
- * Spitzer, Peter G.
Los Angeles, Calif. (M.I.T.)
- Stanley, Samuel L.
Potomac, Md. (The Coll. of the Univ. of Chicago)
- Sunday, Marye E.
Etobicoke, Ont., Canada (Univ. of Toronto)
- Swanson, Richard S.
Winchester, Mass. (Harvard)
- Taylor, Herman A., Jr.
Bessemer, Ala. (Princeton)
- * Teich, Jonathan M.
Edison, N.J. (California Inst. of Tech.)
- Teller, Lynn E.
Brooklyn, N.Y. (Yale)
- Tepler, Isidore
Brooklyn, N.Y. (Columbia)
- Thygeson, Nels M.
Berkeley, Calif. (Univ. of California, Davis)
- Tillotson, Loyal G.
Painesville, Oh. (Ohio Northern Univ.)
- Trilla, Francisco
Queens, N.Y. (Harvard)
- Troen, Bruce R.
Pittsburgh, Penn. (Harvard)
- * Turner, Joan M.
Rancho Palos Verdes, Calif. (Wellesley)
- * Verkman, Alan S.
Queens, N.Y. (M.I.T.)
- Vemon, Walter B.
Dubuque, Ia. (Harvard)
- Villars, Frederick J.
Belmont, Mass. (Harvard)
- * von Schulthess, Gustav K.
Zurich, Switzerland (Edig. Tech. Hochschule, Zurich)
- Watkins, Michael
New York, N.Y. (New York Univ.)
- * Wax, Amy L.
Troy, N.Y. (Yale)
- Weinkle, Dana J.
Coral Gables, Fla. (Princeton)
- Wharton, Melinda
Woodward, Okla. (Univ. of Oklahoma)
- White, Kelley J.
Laconia, N.H. (Dartmouth)
- Wilkinson, Joanne M.
West Roxbury, Mass. (Smith)
- Williams, Ellen K.
Memphis, Tenn. (Radcliffe)
- Wilson, Roy
Suitland, Md. (Allegheny)
- Wornham, Wendy
La Jolla, Calif. (Stanford)
- Yoss, Marci S.
North Miami Beach, Fla. (Radcliffe)
- Zelt, Roger P.
Pittsburgh, Penn. (Harvard)
- Zinar, Carol
Los Angeles, Calif. (Univ. of California, Los Angeles)
- Zucker, Marcia A.
Highland Park, Ill. (Brown)
- Zuckerman, Andrea L.
New York, N.Y. (Radcliffe)

Getting to the core of the clinical curriculum



The need for an evaluation of the clinical teaching at HMS became apparent to the Alumni Council and the Alumni Survey Committee when complaints about this type of teaching were expressed by the students answering the recent Alumni Survey Committee questionnaire concerning student attitudes. Since it was a blow to the egos of all who felt that HMS has always excelled in its clinical curriculum, the Alumni Council decided that a study of this problem might be carried out quite easily by the Alumni Survey Committee. Hence the task was presented to us and the evaluation undertaken in early November 1975.

To obtain information for this report a number of third and fourth year students were interviewed by the Alumni

In November of 1975 members of the Alumni Survey Committee met with each core coordinator and with some of the students during their various clerkships. Kenneth Falchuk '66 (standing, left), the coordinator for medicine at the Peter Bent Brigham Hospital, outlined the basics of his clerkship in medicine. Two of the Alumni Survey Committee members, Donald McLean '43A (left) and chairman William Cochran '52 (right), elicited the students' views about their clerkship experience. The other eight coordinators with whom the Alumni Survey Committee talked were: Mark Peppercorn, M.D., coordinator in medicine and William Silen, M.D., coordinator in surgery at the Beth Israel Hospital; Arnold Weinberg '56, medicine, J. Gordon Scannell '40, surgery and John Robertson, M.D., pediatrics at the Massachusetts General Hospital; Nicholas O'Connor, M.D., surgery at the Peter Bent Brigham; Frederick Lovejoy, M.D., pediatrics and Frederic Frigoletto, M.D., obstetrics/gynecology at the Boston Hospital for Women.

Survey Committee and most of the core clerkships were visited. Those on the faculty responsible for the immediate content and structure of each clerkship were also interviewed. Once again the Alumni Survey Committee was impressed with the frankness and interest of all those who gave of their time for this survey. We started with nine fourth year students who were kind enough to come and meet with us for a four hour

evening session. The following day the Survey Committee broke up into four groups and, with the direct participation of the nine core clerkship coordinators, studied the medicine, surgery, obstetric and pediatric clerkships firsthand as well as the subject of clinical teaching generally. Having been thus exposed we were struck by the many examples of excellent, personalized teaching that we felt make for a well-planned, well-

evaluated flexible program. Among the coordinators we met, there was a sincere interest in what they were doing and trying to do. However there was not always a complete understanding by all involved as to the specific goals of a particular clerkship.

Teaching as a Priority Item

As already outlined in our previous report to the Alumni Council of May 1975, teaching of Harvard Medical students does not seem to be a uniformly high priority item on the clinical services of the various hospitals. Some students reported that at times they were demeaned, considered a nuisance and/or rebuffed in their efforts to gain knowledge from house staff, hospital staff and visits. In part this problem has been created by changes in the size, sex and diversity of the student body, and by certain changes in medical practice and medical settings. Concern on the part of senior staff with financial survival as well as the need to meet legal or other regulatory requirements have complicated matters even more.

RECOMMENDATIONS

There must be clearly articulated expectations by both the dean of the Medical School and the chiefs of the teaching services that teaching of students is to be a major priority of a service. This should encourage quality teaching.

Formal rewards and/or recognition of outstanding teachers with at least some academic protection, especially at the house officer level and for visits, are essential and should be adopted. Such rewards should be so structured that they minimize competition yet are available for *all* who are judged as high quality instructors.

Some services should consider developing special programs for those involved in student teaching to improve its caliber. Consideration should also be given to having teaching residents, individual senior resident tutors and others for as much as one year at a time or longer. When a resident is given a teaching assignment as part of a year's rotation, it should be considered one of the most important rotations and not be relegated to the time when the resident also takes a vacation, or catches up on research, or a backlog of charts.

Students should have maximum exposure to "the best teachers;" chiefs of service who are good teachers are particularly valuable in this regard. Recently students have complained that they had not seen or been much exposed to such individuals at the professorial level.

House staff and visits (especially the latter) should be engaged in large part on the basis of their teaching ability and not only on their academic accomplishments.

Departmental Communication

We learned that there was little intradepartmental communication between hospitals; even within a hospital few interdepartmental meetings occur concerning student teaching or, for instance, what should constitute the content of core curricula. It was sad but true that the meeting we had with the core clerkship coordinators was their first meeting ever as a group to discuss this subject of common interest — student teaching!

RECOMMENDATION

All large departments at the Medical School should have at least semi-annual departmental meetings during which a major topic is student teaching, especially its objectives, content and methods of evaluation.

Student Evaluation

There is inadequate communication regarding expectations for student performance on some teaching services. Indeed, some services fail to use standard criteria when evaluating students.

RECOMMENDATIONS

Each teaching service should have explicitly defined categories and written criteria by which students will be evaluated. Criteria may differ within different rotations of a single service: for example, students on medicine at the MGH may be expected to have greater reading knowledge on the Baker Service, where there is more time for reading; but more team participation may be expected on the Bulfinch Service, where reading time is scarce. However, on all rotations definitive criteria should be written and available to students, house staff and visits alike.

Prior to each course students should receive detailed written descriptions and expectations. At the start of each course, they should see the forms that will be used in evaluating their performance.

Those teachers who evaluate and judge students should make an effort to use descriptive words or concepts rather than letter grades, so that evaluations will be helpful to students in identifying their strengths and weaknesses.

There was a difference of opinion among us as to whether there should be a definite standardization of grades. Most of us thought that perhaps a standard guideline should be used so that, for instance, five per cent of all students would get an evaluation that was "outstanding," twelve per cent one that was "excellent," and the remainder "good," "satisfactory" and "unsatisfactory."

Certainly, the recent inflation of grades in some clerkships and not others has been both confusing and unfair to the students.

Performance Feedback

Neither students, house staff or attendings, are given feedback on a regular formal basis. Sometimes student evaluations are completed but are not handed out soon enough for students to act on the information. On other occasions students are not provided with a genuine opportunity to discuss the evaluations. It is often unclear to all concerned what is done with the results of student evaluations by the house staff and attendings. On most services students do not have a role in evaluating either house staff or visits.

RECOMMENDATIONS

For Students. Each teaching service should routinely provide an *opportunity* (possibly notifying students in writing) for each student to discuss his or her evaluation, including specific strengths and weaknesses of performance. Confidentiality of authors must be protected. Students who desire this feedback must be told it is up to them to take the initiative for making appointments.

End course evaluations should be completed, at a maximum, by six weeks after a course has ended.

For House Staff. They should be evaluated formally by students and visits in

anonymous questionnaires.

They should be provided with opportunities to obtain awards for excellence in teaching and be relieved of teaching duties, insofar as possible, if found to be deficient and/or unwilling.

For Visits. They should be evaluated by students' anonymous questionnaires.

They should also receive rewards and sanctions as outlined above for house officers.

HMS must plan ahead in the event that clinicians who are good teachers may be unable to continue providing teaching time gratis.

Each visit should make clear his or her desires and expectations for the students, especially where these differ from usual course expectations. The visit should be sure such expectations are approved by those responsible for the clerkship.

Clinical Elective Time Away from HMS

Students have recently complained that this possibility has become more and more limited. Apparently it was the feeling of those in charge that too many students were taking clinical courses away from Harvard, partly to get a vacation and partly to "see another part of the world." Within reason it seems that such clinical elective time should be restored to the students. Perhaps a senior HMS physician (especially an alumnus/a) might evaluate those more popular courses to see if and why they are perhaps superior to those taught at HMS. Such evaluations might lead to salutary changes of some present particular courses at Harvard.

Role Models

The minority groups and women once again pointed out that there are few role models available to them, especially at the professorial level, and hoped that improvements in this category would soon be forthcoming.

Scheduling of Core Clerkships

Some core clerkships are now scheduled so that they fall during the months of July and August. It was the impression of the students, as well as the interns, that during these months the interns, who are often the major

teachers, are becoming familiar with their own jobs and are green and unsure of themselves. Thus they are not yet capable of high quality teaching. Also, many visits are on vacation during the summer months, hence the more prestigious visits are often unavailable. Therefore, thought might be given to rearranging the schedule of the core clerkships to exclude the summer months, especially for the third year students.

Important Elements of a Core Clinical Clerkship

The following is a listing of the elements we found in some of the clerkships that seemed particularly important and worthy of incorporation in all of them.

AN INTRODUCTORY PERIOD

Time should be taken at the beginning of every core clinical clerkship not only to arrange individual schedules, but also for students to observe a standard physical examination by a resident or intern for that particular specialty. Third year students should then be given patients to examine during that same introductory session; their physical examination should be evaluated and criticized.

The various hospital departments important to each particular clerkship should be visited and explained, e.g. laboratories, x-ray or social service departments. Students should be encouraged to talk with the other members of the health care team to learn their roles and functions, e.g. nurses, respiratory therapists, physical therapists, among others.

During this introductory period students should also see the forms by which they will be evaluated by the house staff and visits, as well as the form they will use to evaluate their teachers.

TEACHING RESIDENT

Only those residents motivated to take on the serious responsibilities of this job should be so appointed. This should be their primary responsibility when assigned and they should be given (especially if this is a relatively short term assignment) detailed instructions as to what is expected of them.

CORE MATERIAL

Either through clinical case presentations, slide lectures or formal

lectures, the major diseases considered pertinent should be presented. As certain residents or visits become known for particularly lucid and helpful presentations on particular core subjects, their presentations should become a routine part of each rotation if possible.

EVALUATION OF THE STUDENT

As stated above, the students should be shown how they will be evaluated and offered a chance to discuss their evaluation halfway through the course as well as at the end. The evaluation might emphasize two general categories: the ability of the student to carry out physical examination and history taking and to formulate diagnoses; and his or her general attitude and value as a potential intern.

STUDENT EVALUATION OF THE COURSE

This should be an extensive evaluation by the student including rounds, resident teaching, senior staff teaching, opportunities for constructive feedback and so on. If the course is broken up into rotations on various wards, each of these should be evaluated separately. All teachers should be evaluated by name, from intern to visit, so that the chairman of the department can commend or discuss deficiencies as seems appropriate. The strengths and weaknesses of the clerkship should be discussed and practical suggestions for changes should be encouraged.

The Alumni Survey Committee feels strongly that *all* these recommendations are feasible and that their implementation would greatly improve certain of the present clinical teaching rotations.

William D. Cochran '52, Chairman
James R. McArthur '56
Philip F. Partington '35
Marshall deG. Ruffin '36
Joseph W. Burnett '58
Donald McLean '43A
Granville C. Coggs '53
Ruth C. Haynes '52
Scott Nelson '66



Dr. Councilman's last lecture

"Throughout his long life Councilman was a man of ardent and generous enthusiasms. It was this quality, combined with his utter informality, which made him such an inspiring teacher for the young." Thus wrote Harvey Cushing '95 in an obituary upon the death of his colleague in 1933.

William T. Councilman, M.D. founded the discipline of pathology in the United States, together with William H. Welch, M.D. He was noted for his studies of the pathology of tropical diseases, including malaria and amoebiasis — in recognition of this, parasitologists later dubbed a species of amoeba Councilmania Lafleuri. He worked at Johns Hopkins University and Hospital in their early years. In 1892, Dr. Councilman came to HMS as the Shattuck Professor of Pathological Anatomy, and became pathologist to the Peter Bent Brigham Hospital at its opening in 1913.

What follows is Dr. Councilman's last lecture as a teacher of undergraduates in medicine, delivered on December 19, 1921 to the second year class at HMS (the Class of 1924) at the conclusion of the course in pathology. We offer it here — its first publication — for what it reveals of a man, of a gifted teacher, and of an era in American medicine that few now living remember.

I thought I would use this occasion to make some remarks which would be more desultory and vague than those you have been accustomed to hear from me, and say something about my early life and early education.

The period of my life is from 1854 up to the present time, we will say 1922.

I came from Maryland and from a race of farmers and tillers of the soil. I think I have been rather fortunate in that, because I lived on a quite large farm and took part in all its activities. I really know how to do farm work, and I can even now plow, swing a cradle, an instrument of great ingenuity of construction now completely obsolete, bind sheaves of grain, but for a very short period only. I left college at the age of sixteen. The college which I attended I remember not a great deal of, but I had a very good time there. The period from sixteen to twenty-two was spent in various activities which were more or less interesting, and of which I retain a good many amusing memories. For a large part of that time I led a very independent existence and did very much as I chose, so that at the age of twenty-two I wore side-whiskers, considered myself a very ripe individual, and experienced in all the ways of the world. In 1876, when I came home after a visit to the exposition in Philadelphia, there seemed to be very good reasons why I should study medicine. I had the idea myself and was much encouraged in it by my father, who was a country physician.

I thought that I would read medicine for one year, we called it reading medicine, before attending lectures, and go around with my father and see his pa-

tients. He, however, saw the dean of the school who, thinking that they had better gain a scholar while they could, and if it were put off death might rob them of a pupil and his fees, advised that I should at once enter upon my medical career. So I entered into the University of Maryland, going daily from my home. Things there were neither better nor worse than in most of the medical schools of that period. There were about three teachers in the school who made an impression on me, one the professor of anatomy, one the professor of surgery, who in addition to showing us operations on the cadaver, sometimes brought pathological specimens to show the class, and I still retain a very pleasant memory of him. The other was the professor of ophthalmology, one of the most dexterous operators I ever saw, and who had the great faculty of holding your attention at an operation, even though you were at a considerable distance from him, and explaining the steps of the operation as he went along. He also showed the results of his operations, and altogether was a wonderful teacher. In that school one might think that there was no possibility of doing anything. If you memorized the lectures, you had the whole thing. Of course we had examinations. Still, we had objects in the dissecting room, and this was the only contact we had with nature. I became interested in the form and structure of the body. That led me at once into the desire to find out something of form and structure in animals and the farm gave me admirable opportunity to study animals. There were various animals there and these could be killed and studied, and if one was interested in osteology there were various bone heaps on the farm where animals had

been dragged out when dead, and one could get the bones and study their relations. The first animal I dissected was the mole, and I became very much interested in the keeled stemum and the relation between form and function. I had also become interested in the bones of the skull and I got all of the skulls which I could find and disarticulated them; I really had quite a collection of the disarticulated skull bones of a great many animals. I used to force the skulls open by putting corn inside and letting this swell in water, and I remember what great difficulty I used to have in getting out the palate bones. The others were easy, but the palate bones gave me a great deal of trouble, and I imagine most of you men who have studied osteology have had trouble with the palate bones. I had quite a collection of bones, dissected many animals, and enjoyed the work very much. I sometimes remained at home and let the important lectures go and studied the bones. And the first great tragedy of my life was when a little nephew of mine, who had a good head for business, on the occasion of my absence, took my entire collection of disarticulated bones and sold them for a few cents, to an itinerant bone merchant. It was probably just as well, I had the pleasure and profit of making the specimens and the size of the collection and other evils attending it gradually forced me out of my bedroom.

In the second year we had the opportunity of going into the hospital. The school had its own hospital and adjoining this was a small dormitory with rooms for twenty-four men, and for a small sum one could secure residence here and go into the wards and study the patients. That as far as I know was the first time in America that the wards of a hospital were thrown directly open to the students for the purpose of study, and represented a very great advance in medical teaching. I wish particularly to mention this because in the history of medical teaching in this country the University of Maryland has not received the credit for this. It would be difficult now to understand how free we were in the wards. A man had charge of a certain ward at one time, and alternated with the other wards; you had the patients there and could study them and do much as you chose, and treat them. We acted also as ward attendants. We used to catheterize the patients, and I

hope this was done only when it was necessary. We also learned the pleasing process of applying wet and dry cups, which I have never tried since. In cupping we put alcohol in a glass, lighted it, and while it was burning the glass was clapped to the back of the patient, where it would adhere and do much good by diverting blood from or to (we were uncertain which) the inflamed part. Sometimes we scarified the skin and drew out blood, and we also placed leeches on the patients and poulticed them. Poultices were used a great deal in the hospital, and after these had been used to cure the patients they served as nutrition for the fowls which were kept in the hospital yard. There had been little attention paid to autopsies and in a most crude way I used to do the autopsies on the patients who died. I had some experience in making autopsies on the animals which I studied, but that was about all, and although in many cases the autopsies taught me nothing because I did not know how to recognize lesions, still you could occasionally make an autopsy and find a consolidated lung or an ulcerated intestine, and from this gain some idea of the relation between the lesion and the functional disorder. One would recognize a diseased heart, but the very definite association of the lesion with the disease you did not know. Still one gains something from that. During that period I remember that the resident physician in the hospital, who had a crude microscope, showed me the circulation in a frog's web, and few things that I have seen have made such an impression on me. I think it is one of the most remarkable objects which one can see under the microscope, and even now I like to look at a web or mesentery and see the circulation.

I graduated from that school in 1878. In the second year I don't think I attended any lectures, because there were things which I had rather do. I believe I was always something of a rebel, and I always had a great disinclination to do anything which did not interest me. As I look back upon it, I think the teaching of therapeutics was more crude than anything else, the self-limitation of disease was even then but little appreciated, there were remedies for everything, their physiological action and even the character of the disorders of function for which remedies were used but little known. Most of the remedies

were harmless and the human body has great resistance to assaults made upon it.

When I graduated in March, — these lectures lasted only from October to March — I attended the graduation exercises and received the degree of M.D., which qualified me to exercise the art of medicine, which I had so laboriously learned, for the advantage of the public. I heard that there was at the Johns Hopkins University a new sort of an institution called a laboratory. I knew of the existence of the Johns Hopkins University but not a great deal about it. It had opened in 1876 and been in existence for two years. Huxley came on and gave the opening address; my father drove in from the country and heard this address and he came back and told us what an impression it had made on him. This was one of the great addresses of Huxley, and he has given a great many. There seems something remarkable about the opening of this University, for it found awaiting the opportunities which it gave a remarkable group of young men with vigorous minds. I think there were very few of the first professors of the University who were over thirty years of age, the oldest being Gildersleeve, who still lives. He had gone through the Civil War and had lost a leg, and had been teaching in the south. The men, Martin, Rowland, Brooks, and Remsen, were young men, and as young men they felt the invigoration of the fresh breeze and there were no hampering traditions. Traditions may be very important, but they can be extremely hampering as well, and whether or not tradition is of really much value I have never been certain. Of course when they are very fine, they do good, but it is very difficult of course ever to repeat the conditions under which good traditions are formed, so they may be and are often injurious and I think the greatest progress is made outside of traditions. So the Johns Hopkins University started without traditions, and started with young men full of vigor and enthusiasm as its leaders. The University at its beginning made provision for twenty fellowships, each fellow being paid five hundred dollars, and the idea of going to a university and being paid for it made an impression. The instruction was ideal, there were few in the class, we were shown the methods, had large independence in the way we worked, there was no great



“... there is no happiness equal to that which comes from hard work and accomplishment in the subject in which you are interested.”

Having just found out about reinforced concrete, Dr. Councilman made the forms and constructed this enormous bench, with the aid of a skeptical hired man. He posed for this picture at the christening (about 1920).

gulf dividing study from research, and we were aware of and profited by everything going on in the laboratory. The absence of routine and elbow instruction was of great advantage. We were also shown the latest published research on the subjects we were studying, and in a crude way endeavored to follow the methods given, and all seemed very simple and natural. How sad it is to think that such instruction can never in our complex organizations be repeated! Hearing of this new laboratory in physiology, as soon as I had graduated I went up there and by good fortune was accepted as a member of the class by Professor Martin. Everything was done very thoroughly and all the teaching was through observation and experiment, all novel and most enjoyable. In the laboratory there were about twenty of us in a class and several of these were fellows who were at the same time carrying on research work and probably more important than the actual work which we did was the influence of the spirit of the place, which was really very wonderful, and I have never seen anything like it. At that time we must remember that five hundred dollars was at least the equivalent of fifteen hundred now; room and board cost five dollars a week, other living expenses in proportion so that it was easily possible to live decently upon such a salary.

I remained at the laboratory there from March to the end of May and then I had the opportunity to earn some money, which was very agreeable at that time, because up to that time I had been a spender, — not very much of a one though. I knew, however, the advantages of financial independence, for I had been self-supporting from the time I left school until beginning the study of medicine. A friend of mine and of the family had just been appointed resident physician at the Quarantine Hospital, and he offered me the position of assistant which gave me my living and a very decent compensation, I think five dollars a day, which was certainly not to be despised. I went down to the Quarantine and lived, and the first money which I got I spent in the purchase of a Beck microscope, a very inferior instrument, but still one could do a good deal with it. It was my job to visit and inspect all the vessels which came to the port and the intervals of this work I spent in microscopic study.

At the end of the year I had a great opportunity. Martin, the professor of physiology at the Hopkins, and a very wonderful man, used to come down to the Hospital to visit my chief, and he offered me the position of assistant in the laboratory. I had charge of the animals, and helped in the work with the men and had a very enjoyable time. But

the next summer, finding that if I stayed there I would go into physiology and thinking that I had rather stay in medicine, I went again to the Quarantine, and the winter after that I spent at Bay View Asylum, which was the hospital and almshouse of the city.

It is difficult for anyone now to conceive what a hospital at that time really was. The hospitals were run very much cheaper than now. The hospital at Maryland University had a contract with the United States authorities to treat the various sailors who came to the port. There was much contention among the hospitals as to who should get those sailors to treat, the United States paid five dollars a week for the board and treatment of the men, and the hospitals took them and I am sure they made money on the transaction. There was no expense, save food, medicine and poultices, and all these essentials were cheap. Medicine in large amounts didn't cost much, because there were certain cheap stock preparations in the hospital. You must remember there were no nurses; I never saw a female nurse in the general wards of a hospital until I went to Europe, and in Baltimore I think there were none until the Johns Hopkins Hospital started in 1890. The attendance on the patients was carried out by the convalescents. There was no

such thing as bathing the patients, a very time-consuming and costly process which most of the patients who come into hospitals are not accustomed to, and all such frills were omitted. Really the hospital care was something that you can hardly imagine, but the patients generally had enough to eat. They had plenty of medicine, which was given with the idea of benefiting them, and their beds were not what one might term very cleanly, but still they seemed to get along. They had diseases and they recovered from them, just as in our hospitals now, with all the paraphernalia. Of course a somewhat larger percentage of them died, but it was not so very much greater. We used to lose a great many patients from typhoid fever and possibly lost more from pneumonia than at the present time. At Bay View I had the opportunity for carrying on post-mortem work, and I also studied in the laboratory at the Johns Hopkins. I studied inflammation principally and I had very great joy in receiving a prize for the first paper that I ever wrote on the cornea, a prize of a hundred dollars, which was handed to me in a silk purse containing twenty five-dollar gold pieces, — and very gratefully received.

Having been at the marine hospital during the six summer months for three years, and accumulated most of the salary which I received there, I concluded to go abroad. I studied in the hospitals and laboratories of Germany for three years, spending quite a long time in Vienna, and living in Leipzig, Strassburg, and other places. The laboratories there made a great impression on me, as did the teaching. The teaching was very thorough, the methods of instruction were good, and the laboratory work was good. They had a very interesting way of doing things. A man would go to the professor and say that he would like to come into the laboratory and work, and the professor would ask a few questions; he paid his fee, he was taken into the laboratory where the other men were, given a part of a table and a chair and nobody paid any attention to him. The idea of coming up to a man and asking "What shall I do?" was not thought of. Quite probably he would have been told — "Go to the devil!" You had to find out what work was going on, and share it. When you found what you wanted to work at you were given every possible

assistance to carry on that work, the very best method of instruction I think that is possible. Of course, a great many of the men rather weakened under that treatment; it is hard to go into a laboratory and not know how to work at anything, but it is a very good treatment for a man because if there is anything in him it comes out.

In that laboratory there were men working in bacteriology. In April of 1882, Weigert had gone on to see Koch in Berlin, and he came back the most enthusiastic man you ever saw, and told us of the work that Koch was doing in Berlin and said that he had seen the cause of tuberculosis. Just after that Koch's article on tuberculosis came out, and it is difficult to describe the sensation it made; the tubercle bacillus was accepted at once as the etiology of tuberculosis, as it should have been, because it was a most complete demonstration of the etiology of a disease. It came out in the *Berliner Klinische Wochenschrift* in 1882, and has all the charm of original description. Original description has a wonderful charm, so much more vivid than the modifications which follow. There is all of that in that paper, one of the most important things ever done in medicine, and those of you who have not read it should do so. The man who sets the ball in motion is the great figure in life.

I came back from Europe in 1883, very full of all the things which I had learned and with a more or less definite idea of giving the world the benefit of the knowledge which I had attained by practising medicine. But I put off later and later the putting up of a sign showing that I was willing to serve, and finally never put it out, because it seemed to me there were so many other interesting things to do. And as long as one saw the possibility of doing these interesting things without actual starvation, there was no question of the choice, and there should never be a question of the choice. I reasoned that if worse came to worst I had a few acres of land, and I knew enough about agriculture to keep me living. I reasoned that on two acres of good land I could raise all the food I required and something over, and I had considerable more than two acres, but I never had to resort to agriculture for a living. I speak of this because at that time there seemed to be no possibility of earning a living by

teaching pathology, and Welch in New York and I were probably the first two men in the country who tried it. I rather think Dr. Welch took the greater risk because he had not my agricultural resources, though a training and mental capacity far greater than mine.

From 1883 to 1890 I spent a great deal of time at the almshouse, and taught in the two medical schools which were in Baltimore, the Maryland University and the College of Physicians and Surgeons. These institutions were deadly rivals of one another, and I had great difficulty in persuading them that I was absolutely neutral, that I would not take advantage of my position in one institution to traduce the men of the other. After a while I received a position in the Johns Hopkins which gave me something, and for a time I served as coroner's physician to the city. For this the city paid me three hundred dollars, and I held the position for one year, but found it tied me down too much to places and dates, and being of a rather roving disposition I did not care to be at a certain place at a certain time. So I involuntarily, but on the whole willingly, surrendered the position to another physician who had a greater political pull.

There were two resident medical positions in the almshouse which had salaries attached of three hundred dollars, and these were actively sought. The general care was under two visiting physicians who were paid fifteen hundred dollars each and were strictly political appointments. It is singular that under the conditions very good men sometimes held the positions, but generally the reverse was true. I persuaded one of these men that it would be a good thing to hold a clinic and attempt to teach the young men something. At the first clinic a man far gone with tuberculosis was presented. The physician pointed out the emaciation, the depressions over the clavicles, etc., and said "Now, gentlemen, all these things which you can see with the naked eye are the signs of the disease, all the rest are symptoms."

It is a striking illustration of the slowness with which great ideas spread at that time, that in the early 80's knowledge of the importance of the work which Lister had started fifteen years before was not generally known or ap-

preciated. We should have had good surgery, but there was not a basis on which a scientific demonstration could take root, and it took a long time for the idea of the antiseptic treatment of wounds to penetrate; it was not understood, and the practice of surgery gave very bad results.

I remember an episode which seemed to me inexpressibly funny at the time. There was a very well known surgeon operating on a private patient, and I imagine for a considerable fee. This surgeon was supposed to have an open mind, a mind receptive to new things. While chloroform, being much simpler and easier to administer, was generally used, some of the more modern surgeons used ether, but the proper method of administration was not understood. Someone had devised a new method of anaesthesia by which a rubber cone with a lining saturated with ether was forced over the mouth, excluding all air, the patient being practically strangled by CO₂. The brother of the patient was there, and the surgeon was anxious to impress the brother, perhaps he had something to do with the payment of the fee, and he told the brother that this was a new method of anaesthesia which had just been produced, the patient going under rapidly. He said, "I will get you to take out your watch and call out the minutes while he is being given the anaesthetic." The patient struggled but in vain, for there were enough assistants present to hold him quiet by sitting on various parts. There was nothing else for the patient to do but take the anaesthetic, and all seemed to be going well, he gave up struggling, and the brother looked at his watch and said "One minute." Everything was favorable, so it went on, the patient being held still more tightly, the brother said "Two minutes," and still things went on; I had been feeling the patient's pulse at intervals, and suddenly I found that the pulse had stopped, and I said to the surgeon, "The pulse has stopped," and he was much disturbed. He quickly grasped the pulse, confirmed what I had said, and then there was commotion. The windows were thrown open, artificial respiration was started, and there was great confusion. And in the midst of all this the brother was standing there perfectly calm, thinking it all a part of the anaesthetic process, and he said "Three minutes." "But, my God, look at

him!" cried the surgeon. Of course this story could not be told if the patient had not recovered, but he did recover, and the operation was successfully performed, not that day but later.

There came also after that a time in which life was, I assure you, very pleasant and as I look back upon it extremely profitable to me. I was doing various things, writing definitions for a dictionary, articles for encyclopedias, and all the time working and teaching. Among other things I had become much interested in malaria, a very pernicious form of which being at the time prevalent; I had made some contributions to the knowledge of its etiology which were regarded as valuable and had acquired some reputation which was more general than local. Then came another period, the period of the opening of the Johns Hopkins Hospital, and this I think was as remarkable as the first period, that of the opening of the University. I was there for two years of that early period, when there were no students. There were in the hospital a group of men, all young, all very good fellows, all working very hard, and all having a very, very good time. I think it is a very important thing that people should be happy in their work, and if work does not bring happiness there is something wrong, and both at the University and at the Hospital there was that wonderful happiness in work. Now I have told you all this not for any particular moral associated with it, but merely to show you that there are always opportunities; no matter what the environment is, it will always give opportunities. The life could not be repeated now because it is unlikely that similar conditions could arise. I might have done a great deal more, but on the whole I have few regrets, I have enjoyed it and I think I had as much happiness and pleasure as can come to any life no matter what its circumstances, and if anything of importance may be deduced from it, it is this I will leave with you — it is that you should always follow what interests you. Always seek to become interested in something, and when that interest comes follow it, don't hesitate, follow it with absolute courage because it will bring happiness. And after all I think that happiness is something which is to be sought in life and there is no happiness equal to that which comes from hard work and accomplishment in the

subject in which you are interested. I say accomplishment; this is not essential to your happiness, it means a good deal to it, but it is not really essential, because it is the striving and not the accomplishment which is the most important.

As I look back on my long life as a teacher, it seems to me that the most important thing for the teacher is to awaken interest and enthusiasm in his students and to provide them with opportunities of following the interest which is aroused, and in this way we progress. Knowledge cannot be given, it must grow and be slowly formed through our own efforts. It is of no importance whatever to be talked to. I have always rather enjoyed lecturing, I like to talk, and I have gotten I am sure more out of the lectures than any of the men I lectured to because a lecture is often an important discipline to the teacher. It enables him to classify things in his mind, through the lecture he often acquires new ideas. I know that sometimes as I have been lecturing I have seen an unscalable wall rising before the trend of my argument, and I have realized that if I said the next two or three sentences I would run against that wall, and one acquires a nimbleness of wit in finding a way around to the other side. I have enjoyed all that, and I think the lecture is an intellectual stimulus and comparatively harmless to the audience. One sometimes comes from a lecture feeling absolutely elated, and lecturing is a harmless pleasure for it does not really very much matter what the lecturer says.

There is much more I would like to say to you — to tell you what this constant association with young men and how little you have had in return. I see all the faces, many who have been so dear to me, who have sat before me in the past and when I think it is over voice fails me and tears come. As a final word, seek happiness in work, follow with courage where your interest leads, and do not fear the future.

Surgery 1920-24: a valentine for HMS

by Charles B. Huggins

The summer of 1920 was spent amidst idyllic surroundings in Nova Scotia. Day followed day with visits to the mailbox across the lake, always fruitless until late July when, glory be, the notice of admission to the Harvard Medical School arrived. Joy 4+! An emotion of such felicity and depth has seldom recurred in my life. The notice stated that the medical course consisted of eight semesters, of four months each, and that, regretfully, tuition had just been increased to \$225 per annum; a deposit of twenty-five dollars was required immediately to reserve my place. We were requested 1) to present ourselves in Building B on a designated day in late September to commence anatomy and 2) to bring a lab coat and a dissecting set. Our professor, John Warren, physically a giant, stated that the most important thing about the course in gross anatomy was to keep the cadaver

Charles B. Huggins '24 is the William B. Ogden Distinguished Service Professor of Surgery and director emeritus of the Ben May Laboratory for Cancer Research, the University of Chicago. Since 1972 he has been chancellor of Acadia University, Wolfville, Nova Scotia. In 1966 Dr. Huggins was awarded the Nobel Prize in Physiology or Medicine. It was Dr. Huggins who first suggested that we print Dr. Councilman's Last Lecture. We then tempted him to write about his own student days and this "account of the medical student (C.B.H.) at HMS fifty years ago with emphasis on surgery and surgeons — fantastic!", Dr. Huggins has rendered with aplomb.

well-wrapped in moist cloth. When lecturing on the brachial plexus and other complex matters, Dr. Warren would conceal a small card in his enormous hand.

We were assigned to a dissecting room with eight stone tables; on each of these was a mound reminiscent of the human form. Two students were allotted a cadaver. With some trepidation, for this was the first time most of us had seen a dead body, we unveiled our subject. There it was: middle-aged, emaciated, reeking with formaldehyde, sopping wet, very stiff, very cold, naked and female. The Acadia boy wondered — is this for me? Shouldn't I try another line? Will they refund my tuition? What to do? Well, my partner, G. V. Burton '24 and I thought, "Let's give medicine a little longer try." So we turned our skin flaps in the anterior chest wall and before noon we had dissected the pectoralis major and identified its nerve supply crossing the axilla, verifying the structures in Gray's *Anatomy*. At high noon we said to one another, "Doctor, I congratulate you on a masterful job — you are a natural surgeon — let's go over to the cafeteria in the basement of Building A." Lunch was twenty-five cents. Medicine had started with a scalpel; cold steel was never to be far away in my working days in clinic or lab for fifty some years.

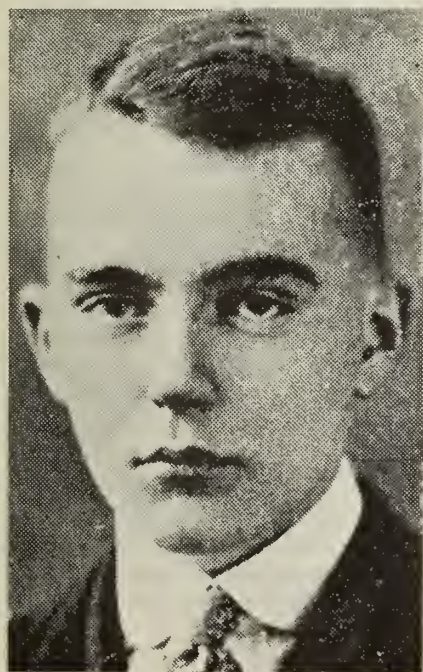
Surgery at HMS in 1920 was a feast of reason and a triumph for technique; the faculty comprised surgeons of great distinction together with a host of young men destined to make important contributions to the surgical field which had

been largely static since Ambroise Paré. The surgeons were the princes of medicine with bright lights, uniforms, flashing instruments and the potential to make brilliant cures in one séance by direct action. The students could feel the esprit de corps which had been contracted on that Indian summer day in 1920 — we had fallen in love with Medicine and the Longwood campus. The vignettes to follow constitute a valentine for HMS.

In Year II there were the wonderful sessions in bone and joint surgery by two young orthopedic surgeons, M. N. Smith-Petersen and P. D. Wilson; both were in their early thirties; both had been house officers with the Harvard Unit in France in 1915. Smith-Petersen was slender and although outwardly appearing melancholy, he had a keen sense of humor in addition to great intelligence; with rasping voice he spoke from the side of his mouth. Wilson was roly-poly, amused with life and always smiling. These teachers exuded enthusiasm; they sparkled. Alternately one of them lectured while the other covered the blackboard with notes and diagrams. Both were contentious; often they had loud arguments, snarling and growling, and of course we adored both of them. We listened with rapt attention. Their subject matter concerned fractures and dislocations, bandages, traction and splints. Take the humerus: there was the dislocated shoulder and how to reduce it; fractures, anatomical and surgical, of its necks, and of the shaft and of the elbow. We learned special treatments for each misadventure — valid to this day — slings, plas-



This photograph of the Class of 1924 was taken in May 1922 with Dr. Harold C. Ernst, professor of bacteriology, who retired from the Faculty of Medicine that year. Dr. Huggins's undaunted first-year lab partner, G. V. Burton (1), stands in the second row at the extreme left. Beside him, bow-tied and with his hair parted in the middle, is P. S. Dukakis (2). In the row of seated gentlemen, the one at the far left is M.S.F. "three-letter" Greene (3). Charles Huggins himself (4) stands just about directly behind Dr. Greene, two rows to the back. Samuel Katz (5), one of this group's "more prosperous friends," is in the rear right. Also near the top of the picture is T. C. "two-letter" Green (6), with a slight smile on his face. Alfredo Hurtado was not present.



Charles Huggins as he appeared in the 1924 Aesculapiad.

ter casts to apply, the clavicular cross, Velpeau bandage, skin and skeletal traction. On and on, all was fascinating. All was stamped indelibly in mind; many alumni of that era have total recall of the sessions. For me, Smith-Pete and Phil Wilson were the high spot of the curriculum at HMS.

It is the teacher who counts — not what is taught. Let the professor know his business (this is not common), impart zest and breathe fire; the result is classic instruction regardless of whether the subject is molecular biology or bandaging. Otherwise medicine can be learned by correspondence.

In Years II and III there were clinics in the out door departments of the Mas-

sachusetts General Hospital followed by a noon lecture at the School. The logistics of transportation were difficult. Several of the students had cars; otherwise there was the Charles Street tram. One of our more prosperous friends, Samuel Katz '24 (later the founder of child psychiatry in America) had a Model T in which he took our gang: P. S. Dukakis '24, Alberto Hurtado '24 (later dean of the faculty of medicine in both universities in Lima) and M.S.F. Greene '24, known to faculty and students as "three-letter" Greene to distinguish him from our classmate T. C. Green '24, *soi-disant* "two-letter" Green. Sam Katz hated to crank up. He charged all passengers ten cents per ride, except for the gentleman who cranked. Fortunately, no disaster occurred. In a sense it was disappointing since we kept splints in the car and were prepared to reduce a

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In Year III, Charles Huggins was instructed in the art of skillful surgical intervention by E. P. Richardson '06 (the father of the Bulletin's editor, George S. Richardson '46).

Colles' fracture in the middle of Huntington Avenue if necessary. Arriving at the School, we literally ran to the lecture hall. I cannot recall a lesson which was not well-prepared since topics were assigned some months before. Some of the lecturers said, in effect: "It is an honor to lecture to a class at HMS."

✂ In Year III, a section consisted of a group of eight to ten students. One late afternoon we gathered at the emergency room of the MGH to examine a pretty young girl, about twenty-two, who had just been admitted with an acute abdomen. Gravely we examined the patient and offered a differential diagnosis: ectopic pregnancy, salpingitis, or appendicitis. After a short discussion, we placed our bets and our teacher, E. P. Richardson, instructed the resident surgeon to explore through a midline suprapubic incision. Before

the end of the hour the surgeon was back with the specimen — an appendix, huge, red and gangrenous. The resident was Edward Delos Churchill, scarcely older than the students, and designed for greatness. I am sure that all of us prayed: "Dear God, let me be like Pete Churchill."

✂ In Year III, Harvey Cushing '95, gave noon clinics on Friday in the great amphitheater of the Peter Bent Brigham Hospital. As principal architect of modern neurosurgery, he was the most distinguished member of the Faculty of the Medical School. His clinics were attended by the entire class; usually there were famous visitors, often the most outstanding surgeons of our time: W. J. Mayo, Evarts Graham, René Leriche.

In 1924 Harvey Cushing, age fifty-five, had a bird-like spare figure weighing about sixty kilograms. He was handsome, an aristocrat, well dressed, intense. He was incredibly industrious — at home in his study were two desks, a desk for standing and one for sitting — and had great artistic talent — in making chalk drawings on the blackboard he was Leonardesque.

In his clinics, Dr. Cushing would choose from the class list two students who were invited to come down front to discuss the clinical case with him. We had ambivalent reactions — terrified that we would be summoned and fearful that our names would not be called. One of my colleagues still remembers his discussion with Dr. Cushing of the mechanism of exophthalmos in Graves' Disease.

Harvey Cushing was most kindly and hospitable. He was given to entertaining at lawn parties complete with tea marquee at his gracious home in Brook-

line. One remembers Dr. Cushing, surrounded by a coterie, discussing the noble iambic pentameters of the *Anabasis* — obviously a slip of the tongue since Xenophon wrote prose. Other teachers called us men; Dr. Cushing always said, "Hello, boys."

✂ At the Massachusetts Eye and Ear Infirmary Dr. Harry Aldrich Barnes demonstrated how to perform tonsillectomy as an office procedure on children under ether anesthesia. A rhetorical question was: what do you do if you nick the anterior faucial pillar? Answer: nick the contralateral one symmetrically and the accident will never be detected.

✂ Harris P. Mosher '96 instructed in otology with head mirror and tiny hand-held speculum. The hardest part of this examination was to find the ear. There were nine of us in this section and at the end of two weeks we had a practical examination: examine the drum of a patient and write our diagnosis on the blackboard. The results were: bulging, three; normal drums, three; retracted, three. Dear Dr. Mosher's comments were: "Profanity" and "I give up."

✂ Gynecology was taught by Professor W. P. Graves '96, chief surgeon at the Free Hospital for Women. Handsome and athletic, Professor Graves had played football at Yale College. He was extremely dexterous and communicated to his surgical nurse with hand signals. We students called the most common procedure The Round Trip: D & C, anterior and posterior colporrhaphy, perineorrhaphy, ventral suspension of the uterus. In the outdoor clinics the students inserted vaginal tampons of glycerol or ichthyol; the indications for these different therapeutic modalities were not clearly stated.

Graves began his first lecture of our course: "Physically, mentally and emotionally women are inferior to men."

Year IV was the time for clerkships on the wards and for electives. In months the time allocated was: medicine, two to three; surgery, two to three; obstetrics, one; pediatrics, one; electives, one to two. Clinical medicine was taught in depth; additional elective time was best spent during the summer vacations.

Clerkships at Boston City Hospital were practical and popular. The clerks spent Saturday nights suturing lacerated scalps of drunks after which the stomach of the inebriated was pumped. "An intoxicated gentleman shall not be dismissed with a full stomach." There was a geography to the Saturday night syndrome: it appeared to us that all the males of South Boston required the ministrations of the clerks on the Harvard Service; by contrast the citizens of the Back Bay never needed the talents of the clerks at the Brigham.

In 1924 F. H. Lahey was a professor at HMS and attending surgeon at Boston City. He was magnetic and high-strung but with quiet demeanor, doubtless one of the great surgical technicians of all time. Combined with all this was lucidity of thought and deep sympathy for mankind. There were the famous Lahey clinics on medical and surgical diseases of the thyroid. These clinics, which lasted three hours, were always attended by huge crowds of medical students from all of the medical schools in the Boston area. It was like a performance of King Lear or Parsifal. We sat packed in the large surgical amphitheater as the great surgeon scrubbed up and performed three thyroidectomies — for thyroid cancer and adenoma, for thyrotoxicosis. The Lahey operations were very safe and very fast. At the end of this tour de force the students were emotionally exhausted with the wonder of Surgery at its best.

The clerks at the Brigham were devoted to this cottage style hospital which we had requested and to which "Dean" Dot Murphy had assigned us. There were four senior surgeons there.

David Cheever was handsome, scholarly and patrician. His forte was surgical anatomy, which he taught as an elective in Year IV, combining precise knowledge of the human body with much surgical lore. In the OR he was unsurpassed in the repair of difficult hernias. Dr. Cheever had a wax model of the human brain that he used in teaching surface anatomy. In retrospect it would appear that the expensive Parisian model was structurally unsound. While being passed around in class one day, it disintegrated most unexpectedly into twenty pieces in the hand of an embarrassed student who said, "I'm sorry, sir, but I was just holding it in my hand." Good-natured Professor Cheever replied, "That is what Mrs. Cheever says when one of our Limoges teacups shatters at home."

John Homans, friendly, practical and a diamond in the rough. He was an authority on the surgery of the biliary tract and devoted much time to telling anecdotes about his Bostonian surgeon ancestors. "For tuberculosis of the glands of the neck my father considered liquid peptonoids in creosote to be almost a specific." In the operating room John Homans would say, "Do you think this structure is a nerve? Let's cut it and see."

Elliot Carr Cutler '13, handsome and athletic, brilliant and innovative. In the spring of 1924 in the female medical wards one of the patients was a young girl with mitral stenosis whom we had been requested to work up with special care; a presystolic bruit could be heard without a stethoscope. One morning she was absent from her bed — she had gone to the OR for cardiac surgery. On this day Cutler performed the first clinical cardiac operation in America. Through a purse-string suture in the apex of the ventricle, he introduced via a small incision a punchlike instrument (valvulotome) into the heart; it had been intended to guide the instrument to the mitral valve by invaginating the auricular appendage, but this was solid with thrombus. Tissue was excised but unfortunately after a week the patient succumbed with lobar pneumonia. Cutler had devised his procedure following many cardiac operations on dogs in the experimental laboratory of surgery in Building C.

Harvey Cushing. What was it like for a student to scrub with Cushing? The substitute house officer rose by 6:00, examined the urines and did the blood counts. My schedule was: a brief visit to the wards, a cup of coffee on the run and then off to the OR for, often, a nine-hour operation. In addition to the master surgeon, in 1924 the Cushing Team usually consisted of: Gil Horrocks '27, the resident, T. J. Putnam '20 and the house officer or clinical clerk. Always present was Cushing's personal orderly, Adolf Watzka, with white pillbox cap, white jacket and sky blue trousers. Adolf did the lifting and adjusted the headlight. Cushing was a deliberate surgeon who practiced the Halsted technique.

Conclusion. How does Medicine '76 compare with Medicine '24? In some ways it is better today; in other ways it is worse.

1976 Better. The semi-centennial advances in medicine through science have been spectacular. Science is the art of our century.

1976 Worse. The curriculum is worse. 1) Medicine is taught in smatterings, not in depth. 2) The three semesters devoted to the basic sciences have been eroded by theft and disastrously replaced with trivia. 3) There are too many students in each class.

L'Envoi

Quantity is the enemy of quality. Harvard choose! You cannot have both.

HMS '36 salutes (?) '35

by Franz J. Ingelfinger

Franz J. Ingelfinger '36, editor of the New England Journal of Medicine, is also an editorial board member of the Alumni Bulletin. Dr. Ingelfinger spoke last year at the fortieth reunion of the class of 1935; however he was "puzzled why this distinguished cohort of 1935 should want to hear from a callow 1936 graduate. The invitation, I finally decided, should be accepted as evidence of your willingness to listen to the younger generation. You must also be a very liberal bunch — in spite of what I read in your class report about your personal reactions to life."

In medical education, the influence of those who immediately precede us is immense. The resident teaches the intern, the intern the fourth year student, and the fourth year student him in the third year — and in view of the condition obtaining in our student days, I do not have to add (thank goodness) a "her" every time I mention a "him."

Thus it is ineluctable (an editor has to use fancy words) that my class, that of 1936, was to a large extent, and for better or worse, educated by you, the class of 1935, both while in school and often enough during house officership.

Ordinarily we honor our teachers. Hence I reluctantly and with heavy heart report to you that 1936 finds dubious benefit in the instruction it received from 1935. Indeed, some of the more radical — perhaps one might label them "foreign elements" in our class — F. Sargent Cheever, for example, or Francis Cabot Lowell — are agitating for a complete break.

What are some of the specifics on which we fault you?

You taught us, in the first place, false values. You told us we would be doctors who would take care of patients. How misleading — in view of the fact that we are providers servicing consumers. You made us believe we were entering a profession but now we have discovered that we entered a cottage industry.

You held up to us false prophets — Sir William Osler, Francis Peabody and Worth Hale.

— Sir William Osler who wrote, "And lastly, the profession of medicine is distinguished from all others by its singular beneficence. It alone does the works of charity in a Jovian and God-like way, dispensing with free hand truly Promethean gifts. . . We form almost a monopoly of trust in this business. Nobody else comes into active competition with us, certainly not the other learned professions which continue along the old lines. There seems to be no limit to the possibilities of scientific medicine, and while philanthropists are turning to it as to the hope of humanity, philosophers see, as in some far-off vision, a science from which may come in the prophetic words of the Son of Sirach, 'Peace over all the earth.' " That, Sir William, is what we call a cloudy crystal ball.

— And Peabody who promoted such outmoded homilies as "Medicine is not a trade to be learned but a profession to be entered."

— And as for Worth Hale, why he blindly adhered to the work ethic and was downright nasty — even at luncheon in Vanderbilt Hall as you may well remember — to any student whom he suspected of goofing off.

You did not prepare us for those who today decry the doctor's dominance and paternalism, who want him to be just another team member along with dentists, nurses, pharmacists, nutritionists, social workers, administrators, systems engineers and a variety of what is called physician extenders (words that always makes me think of a physician stretched on a rack — quite appropriate in the context of this talk). You held up to us unworthy goals; by your example you made us disguise our true selves. We wore neatly pressed pants, coats, shirts and even ties. We were polite to our teachers and wrote down notes of what they said. But we now know from the truths revealed to us in the last decade that the student-teacher relation is an adversary one. The student stomps and yells, or disdainfully walks out of the classroom when the teacher's performance is sub-par in the sense that he may be discussing calcium balance (irrelevant, of course) rather than the availability of milk in the ghetto. Just think what we of '36 — and perhaps even you of '35 — missed by not shouting down, well, let us say a Henry Jackson or a Burt Wolbach. How did you prepare us for the fact that a gastroenterologist lecturing on malabsorption to a Harvard Medical School class would be threatened and told "don't give us that crap: we don't want to hear

about the gut, we want to hear about malnutrition.”

Furthermore, you promoted in us competition, snobbery and elitism. I very well remember being scolded by Dave Clement for getting a C— on a case presentation, but — far more reprehensible — I allowed myself to be congratulated by Charlie Roberts for getting a B+. How immature did you want us to be! You had us worked up, moreover, about clubs — Lancet, Nu Sigma Nu and all the rest, when, instead, we should have been organizing protest marches with no special purpose except that of smashing up a few expensive pieces of equipment and roughing up an authoritarian figure or two.

You did not exemplify for us good learning habits. I don't remember any one of you, for example, reading the *New England Journal of Medicine*. But even if you did, I wouldn't have recognized the sheet, for I certainly never looked at it in my student years. If I had, I might have been better prepared. Let me quote to you, for example, a few of the *Journal's* contents in the first half of 1935, the time you were preparing to receive the degree of P.M. — Provider of Medicine, of course.

Here in the January issue we find an article by Henry Jackson and Frederick Parker promoting the idea that agranulocytosis might be a disease and that, though “the etiology of the condition must for the present remain uncertain” — “aminopyrine and its allies may and probably do have much to do with the development of certain cases.”

And in the January 31 issue is an editorial on — guess what — “Health Insurance.” Honest to goodness! Let me read you the last three paragraphs of this editorial.

The medical profession has been tardy in a general showing of interest in health insurance partly because there has been a somewhat general condemnation of all such plans by some influential professional bodies, this condemnation having been based on the experience of some foreign countries.

This movement is growing stronger and demands of the medical profession study as to plans which will not

exploit the laity and which will be fair to physicians. It does not seem impossible that civic organizations should be found willing to unite with doctors, and, after a study of community needs and resources, provide organizations operating without profit to inspire the low-income groups to take advantage of wholesome forms of health insurance. The benefits will be common to patients, hospitals, and doctors.

It must be recognized that unless influential doctors have very definite influence in shaping these plans, much harm will result. We do not want legislation formulated and managed by politicians. This should be averted by voluntary organizations.

I don't recall you, Dr. Soutter, bringing this to my attention.

And in the issue of May 2 is an article entitled “Physician and Patient as a Social System” in which the medical profession is urged to become more aware of sociologic precepts by, of all things, a professor of chemistry. His name was L. J. Henderson. “When you talk with a patient,” he wrote, “you should listen, first, for what he wants to tell, secondly, for what he does not want to tell, thirdly, for what he cannot tell. You must take special note of his omissions — in listening for these omissions you must make use of every aid that is available. Among the available aids are the results of psychoanalysis. Many of them are well-established; but if you wish to preserve a scientific point of view, you must beware of psychoanalytical theories. Use these theories, if you must use them, with skepticism, but do not believe them, for they are themselves in no small measure rationalizations built up by an eager group of enthusiastic students who are unquestionably seeking new knowledge, but whose attitude is strangely modified by a quasi-religious enthusiasm, and by a devotion to the corresponding quasi-theological dogmas.”

In the May 23 issue there were two letters of interest. Here is what a prominent Massachusetts surgeon wrote about one of his patients.

Ten days after her admission to our hospital, I returned from the South to find myself confronted with a problem

as perplexing as any one of us has ever been called upon to face. The outcome of the case in itself from any point of view was highly problematical. The press correspondents were numerous, ardent and eager. They manifested some evidence of becoming rapacious. They claimed title to news and would not be unslaked.

May I state briefly that the intrusive publicity involving the first of our recent cases of diaphragmatic hernia has been as disquieting as it has been regrettable and burdensome to me and all other members of our hospital staff.

Do you remember that case? It was that of the little girl with an upside-down stomach who came to the Truesdale Hospital in Fall River. Dr. Truesdale's letter was referred to the Committee on Ethics and Discipline of the Massachusetts Medical Society. That committee found the press as guilty as it has been found by physicians ever since:

An Omaha newspaper, sensing the news value of the case, exploited it and asked for subscriptions to defray the patient's expenses: a local business magnate responded nobly. Here was an impressive and striking situation, — philanthropy, science, and art uniting to help an appealing little sufferer through the agency of a physician who generously offered his services gratis, as every decent physician has done since time immemorial. The newspapers of the country made the most of it and purveyed to the highly emotional, idealizing, sensation-loving and sometimes hysterical American public the mental pabulum which it loves.

The committee, although it proclaimed Dr. Truesdale an ethical physician, did not give him complete clearance: “If he had been prepared to confront one of the most trying situations of its kind ever faced by a physician in this country, he might have been able to limit the publicity which has been deprecated by most members of the medical profession.”

And who was the chairman of the committee making the report? None other than David Cheever.

Of course, even if you had taught us to appreciate the *New England Journal of Medicine*, I am not sure that it would

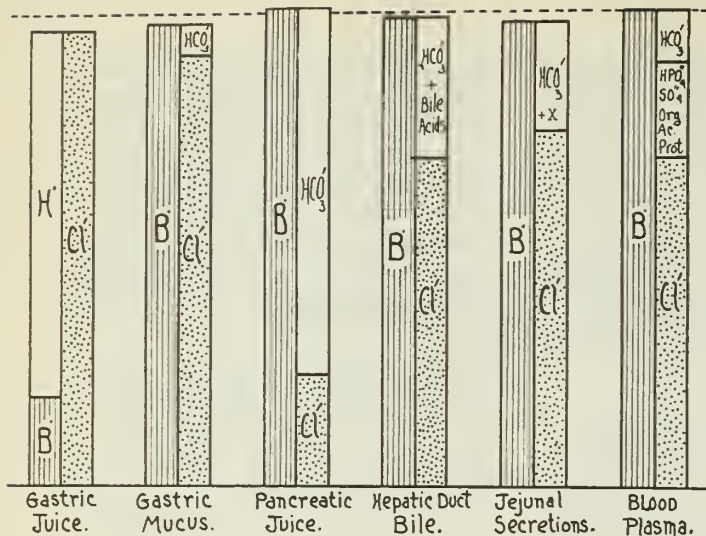


Fig. 1. A Gamblegram

have helped us much. For the science in those days was fairly elementary, and about the most difficult metabolic patterns we had to learn is the one shown here (Fig. 1). Even administrators among you must remember these Gamblegrams, or "Ionic columns" as we liked to call them. But now the *Journal* is above printing anything as simple as that. In response to the insistent demand that if our diagrams of metabolic pathways have to be so complicated, they at least should be relevant, one of our forthcoming issues will contain a Medical Progress article on the metabolism of Geritol, the essential features of which are depicted (a simple word like "shown" is taboo these days) in Fig. 2.

Consider also the changes that have taken place in how the doctor goes about deciding on a proper diagnosis and treatment. We were taught what seems to me to have been an algebraic method. Faced with a clinical problem, the doctor used this method to organize the information he had, to look up the information he didn't have, and then to create an equation to solve a specific problem presented by an individual patient. It was a mode that required knowledge, thought and ideally some wisdom. Now I am not trying to impute these qualities to you, but you failed us by accepting the algebraic system from the faculty without protest, and how could we help but similarly accept, in a supine fashion, the supremacy of knowledge, thought and wisdom?

Nowadays, however, only the obsolete use algebraic formulations; those who

are with it use algorithms. To illustrate an algorithm, let me discuss the not uncommon symptom of sneezing. The performance of this phenomenon, I submit, can be analyzed as resulting from a burst of sequential decisions. Fig. 3 shows the hierarchy of decisions — incomplete to be sure — that a desire to sneeze calls forth. Suppose, however, you are unacquainted with the finer points of sneezing, at least as practiced in developed countries. You might then, should you feel impelled to sneeze, approach some variety of health care provider and ask for guidance. This provider would then whip out a handbook and instruct you in the protocol to be observed — here indicated by the heavier lines — as you responded with affirmative action to the desire to sneeze. Such a guide or protocol or flow chart that is observed routinely in response to a given precipitating event, is known to the cognoscenti as an algorithm.

Algorithms were introduced into medical practice to guide physicians' assistants in performing certain routine tasks, chiefly diagnostic but some also therapeutic. To use an algorithm successful-

ly, certain skills are of course necessary:

Ability to read and speak — but not necessarily to spell.

Knowledge of a given list of medical terms.

Ability to carry out the medical procedures contained within a specific set of algorithms.

Responsibility in following instructions.

Docility.

More recently, however, algorithms have been promoted to guide medical care provided, not by the physician's assistant, but by the physician himself. One that appeared in *Gastroenterology* is shown in Fig. 4; it purportedly tells a physician how to go about testing a patient suspected of having hepatitis. To the physician trained to think algebraically, this is a hopeless maze — indeed it is a hopeless maze to anyone, for even in the original it is totally illegible. Fig. 5, however, reproduces part of an algorithm that can be read. It appeared in *Patient Care* and claims to show a physician just how to handle a case of anemia.

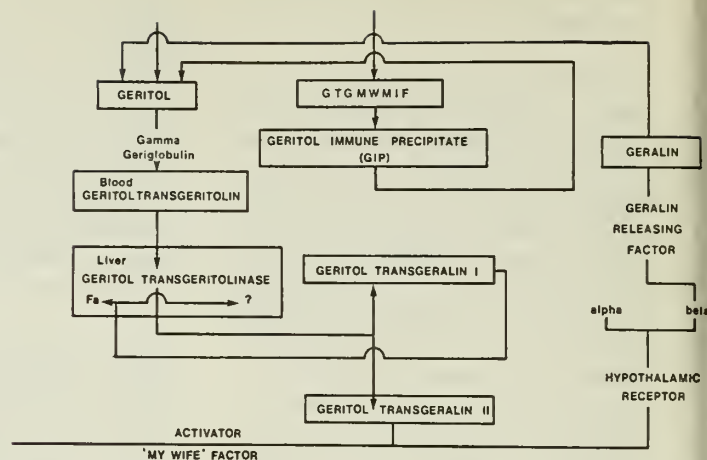


Fig. 2. The ingestion of Geritol is indicated by the arrow at the top left-hand corner of the figure. It is then carried in the blood by Transgeritolin and reaches the liver, where hepatic enzymes split it into Geritoltransgeralin I and Geritoltransgeralin II. The fate of Transgeralin I is somewhat uncertain except that it returns to the liver and deposits huge amounts of iron. Geritoltransgeralin II enters two pathways. One of these constitutes a positive feedback loop, the other a negative feedback loop. The positive feedback loop, working through hypothalamic receptors and releasing factors, leads to Geralin which in turn stimulates the intake of more Geritol. On the other hand, Geritoltransgeralin II is activated by the "my-wife factor." This produces such a major reaction that it cannot be shown on the figure and the metabolic vector therefore goes off the figure, makes several turns in space and then returns (top center) where it leads to the production of Geritoltransgeralin my-wife migratory inhibitory factor. This in turn leads to Geritol Immune Precipitate, or in its acronymic form, GIP. A definite inhibitory effect with respect to Geritol intake is thereby produced.

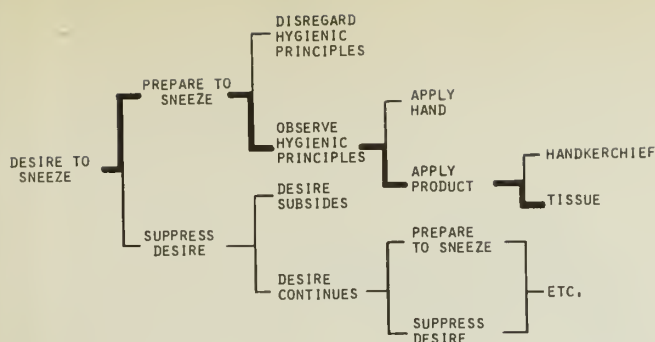


Fig. 3. How to Sneeze

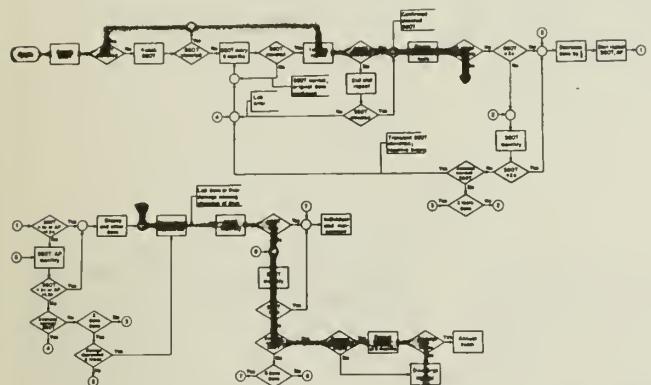


Fig. 4.

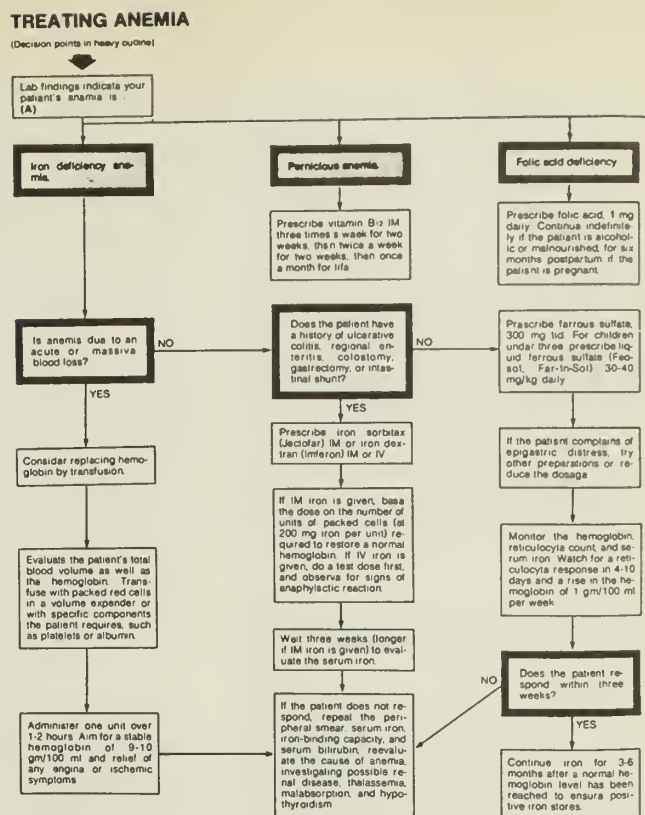


Fig. 5.

The increasing intrusion of algorithms in medical practice not only puzzles us algebraicists; it also threatens to make us useless. For what is the difference between an algorithm-using physician and an algorithm-using physician's assistant? Precious little, except that — as study after study has shown — the physician's assistant uses the algorithm more effectively and reliably than the doctor, and is happier doing so. In other words, increasing use of the algorithmic mode will devalue the physician. Not only his intellectual way of life, but his social status will suffer, for surely the common use of protocols for diagnosing and treatment will erase the distinction between the physician and his assistant. Indeed the social effects of algorithmic dominance in medical practice will make the threats posed by "socialism," or the ideologies of Lenin, of Mao, and even of Teddy Kennedy seem pale by comparison.

And finally, what about women? Yes, women. I have to reveal to the wives here assembled that your husbands, by their example, led us '36ers to think of women as sex objects. Furthermore, both of our classes, I am ashamed to admit, laughed about women doctors. We called them "hen medics" and some of the gentlemen here, I recall very well, unabashedly told jokes about them. And I am sure one of you first

passed on to me Oliver Wendell Holmes's definition of a woman, namely "a constipated biped with a pain in her back." The autocrat of the breakfast table obviously can be written off as an MCP.

So our reaction today to the feminine invasion into our formerly near-exclusive domain of medical practice tends to be one of continued insensitive chauvinism or one of embarrassment — both bad. We continue to display what a lady assistant dean at HMS has called — in the *New England Journal of Medicine* of course — a demeaning attitude towards women. We treat them lightly as patients and we insult them as doctors. We even go so far as to say, "look at Dr. XX. She is not only smart but boy, is she built!" but we don't go as far as a Harvard faculty male who, I understand, once wrote a letter to the *Alumni Bulletin* complaining that the admissions committee had admitted a female medical student so voluptuous as to distract both class and teacher.

Or, as I say, we get embarrassed when our women colleagues demand equal access to athletic equipment, locker space, showers and even more intimate facilities. Even an editor is somewhat shocked at the letters he receives from what we gallants used to call the fair sex. As some of you know, the

Massachusetts Medical Society has launched an advertising campaign urging the public to smoke less, eat less and drink less, and the slogan of the campaign is "Fight self pollution. It's in your hands." To which a pretty young thing of a librarian wrote to the *New England Journal of Medicine*, "Please see Dorland's illustrated medical dictionary 24th edition. 'Fight self pollution. It's in your hands.' It certainly is." After considerable debate, we decided we could print this comment without too seriously damaging the sedate Brahmin image of the *Journal*.

Now I will admit, gentlemen of '35, that my reproach about what you taught us was concocted as I sat in the editor's chair, the most ivory of ivory-towered seats. But my thesis, I now suspect, is flawed. Presumably you have observed in your professional life the same precepts and practices that you taught us. Yet, as your class report modestly allows, you have been a "fruitful and productive lot," your achievements are recognized even by those who are not members of your class. You are all beaming with success. So as I look forward next year to our fortieth reunion, I now venture to predict that the members of '36 will be similarly content, not in spite of what you taught us, but because of what you taught us.

AHA!

by Gordon A. Donaldson

Gordon A. Donaldson '35 has represented the Harvard Medical Alumni Association to the Associated Harvard Alumni for the past six years. As little if any information has appeared in the pages of the Alumni Bulletin about the Associated Harvard Alumni organization, Dr. Donaldson thought it appropriate that he "should report to my fellow alumni/ae at the termination of my stewardship."

Why should the affairs of the Associated Harvard Alumni be of interest to Harvard Medical School graduates? As the years have gone by, some of our graduates have detected cracks in the shield of fair Harvard, and at times it has seemed that the lettering of "Veritas" has appeared in disarray. Nevertheless, it must be recalled that every alumnus/a — bright-eyed and eagerly, even with a touch of pride — once made a choice to attend a medical school called Harvard. The ever-growing stream of applicants, presenting themselves to the admissions committee year after year, gives continuing confirmation of the position our Medical School holds in the eyes of the young. Therefore not only should our alumni be interested in the Associated Harvard Alumni, they should also share a degree of responsibility in this multifaceted organization, so that it might continue to "plant trees to benefit yet another generation."

The AHA is a gigantic organization with a tight network of communication within the United States, and lesser ties to Harvard Clubs around the world. The

association is the result of the amalgamation in 1965 of two parallel groups in the University, the Harvard Alumni Association and the Associated Harvard Clubs. The one hundred Harvard Clubs now in existence continue to provide a structure for the present parent organization. Anyone whose name appears on the alumni records of Harvard University is automatically a member of the Associated Harvard Alumni. A happy and unique distinction of this association is that there are no annual dues!

The association's purpose is "the promotion of Harvard University, and the establishment of a mutually beneficial relationship between the University and its alumni." More specifically, efforts are directed to bringing information regarding the University to the alumni; establishing an atmosphere of trust between the alumni and the College; encouraging communication among the alumni groups themselves; and promoting a continuing education program. Nowhere in these objectives is there mention of raising monies or is there evidence of interference in admission policies, curriculum standards, athletic programs, or other functions.

The directors of the AHA number seventy-five, eighteen of whom are chosen "at large" by Harvard University alumni. Twenty-five are appointed as regional area directors. And seventeen are appointed, like myself, to represent a particular group of graduate school alumni or other special interests. The term of office is three years, limited to a single reappointment. The various

officers and directors hold three two-day meetings (October, January, May), and also attend the annual meeting of all alumni in June, on Commencement Day, all of which are arranged by Peter Shultz and his staff at Wadsworth House.

The specific responsibilities of the AHA are numerous and varied. Representative of the nineteen or so committees intimately involved in the functioning of the University are those for nomination of candidates for Overseers to the University, elections, reunions, Harvard Clubs, resources (both human and financial), prize book awards, schools and scholarships, communications and publications, meetings, continuing education, undergraduate relations, recent graduate relations, Radcliffe relations, and relations with graduate school alumni organizations.

Most of the appointed directors from the graduate schools are happily on this last committee. For the past six years we have been actively engaged in planning greater involvement of the alumni of the graduate schools in University-wide activities. The Medical School is fortunate in having a strong central office in Building A, where the location and activities of any graduate can be found simply by referring to the proper class reunion report. Afield we are more weakly organized.

Unlike the Law School, which boasts fifty area clubs, and the Business School, with sixty local organizations throughout the country, the Medical



School has the support of only eight area "cells." The reasons for this are many, the most obvious being that our graduates are already flooded with commitments to other medical and social activities. Furthermore, like alumni of other graduate schools, Harvard men and women come from many colleges, and if they return to those same environs, tend to focus their support on their first alma mater. And then, as professionals, medical graduate school alumni often become affiliated with other university graduate school faculties. As administrators or as teachers, they are faced with understandably conflicting loyalties.

In those areas where medical alumni clubs or organizations are established and functioning, we do not plan to interfere in any way. In the many sections of the country where there is no communication among the alumni of Harvard graduate schools we intend to develop the "umbrella concept:" greater participation of the varied groups under the aegis of the already established Harvard Club. Unlike the clubs of the Northeast, most of the Harvard Clubs south of Washington and west of the Mississippi now have a majority of non-College dues-paying members, and many non-College alumni serve as elected officers. At the present time, with the Director of Alumni Relations, Perry Culver, we are in the process of identifying a loyal medical alumnus/a in each of the ninety Harvard Club areas who will serve as a director and act as a catalyst for the benefit of all Harvard Medical School graduates in the area.

Assistance in the programming of speakers for Harvard Club meetings, in interviewing for the admissions committees, in the identification of promising athletes and the selection of Harvard Book recipients, as well as support for fund raising, are only a few of the fringe benefits that would come from such a move. If each of the graduate schools is successful in fostering such groups under the umbrella of the existing Harvard Club, then one of the objectives of the Associated Harvard Alumni — the establishment of truly "Harvard University Clubs" — will have been attained.

Book Review

Talk Back to Your Doctor: How to Demand (& Recognize) High Quality Health Care. Arthur Levin, M.D., Doubleday, Garden City, New York, 1975. 245 pages, \$7.95.

The incontrovertible assumption of this book is that the better informed patient will receive better health care. Toward this end, Arthur Levin '65 has covered in helpful detail how to choose a doctor (good, better, best); how a diagnosis is made; what to expect from a visit to the physician; what tests might and should be ordered; what kind of physical examination the patient should receive; how advisable it may be to seek another opinion; how to identify good and bad hospitals; how to avoid unnecessary surgery; how women can protect themselves from needless operations and tranquilizers; how parents can make sure their children get proper evaluation and reliable care. The author gives good evidence that a patient's skepticism can truly be healthy.

While I agree completely with the intent of this volume and with almost all the facts, I find disturbing its academic provincialism and rather unrealistic expectations. Frequently and unequivocally, the author states that the best doctors and the best care are at university hospitals (list given). If so, should the "elsewhere" patients journey for treatment to the true dwelling place of Aesculapius? After all, it may do little good to "talk back to a doctor" who is unable to arise to the therapeutic occasion even under the stimulus of an informed, verbal challenge.

In his prescription for selecting the proper physician, the author advises an age range between thirty and forty-five. But since most specialists finish their training by thirty-two and hit their stride by thirty-seven, there is only a short golden period of patient care before the forty-fifth birthday knell has sounded.

Another example of good but-hard-to-follow advice is Dr. Levin's admonition: "You should choose a physician who makes a continuing effort to keep his



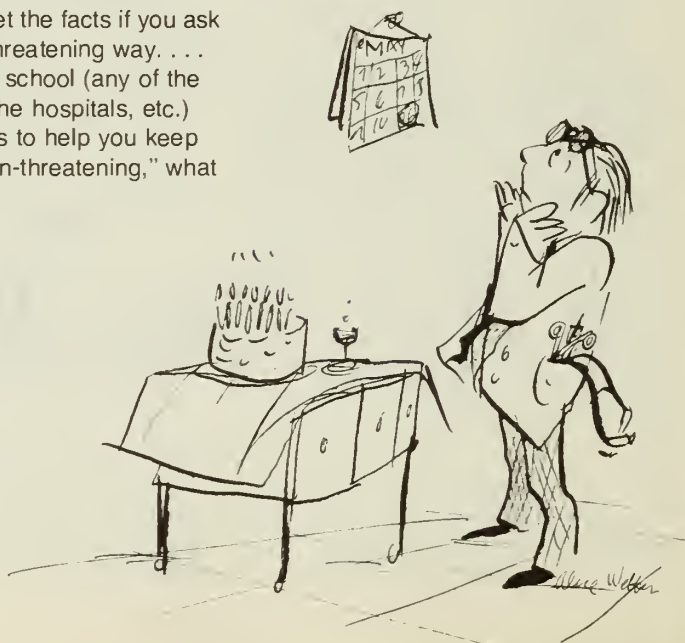
knowledge current." Agreed — but how is one to know? Dr. Levin suggests asking: "Does he teach? . . . Does he read medical journals? You may have to wait until your first visit to determine this (unless you can get the doctor or secretary to tell you in advance). Count the different journals you see. . . . Some doctors keep their journals at home. If you see none in the office, you can easily find a tactful way to ask the doctor about his reading habits: 'You must have to read a good deal in order to keep up with things. . . . Does the doctor participate in other self-education activities? . . . Again, the best source here will be the doctor himself. You can usually get the facts if you ask in a casual, non-threatening way. . . . 'Does the medical school (any of the medical schools, the hospitals, etc.) have any meetings to help you keep up?' " If this is "non-threatening," what is threatening?

The basic question is whether the patient for whom this book is intended will read it and incorporate its messages and insights. Will a person going to a neighborhood health clinic make a special trip to the public library, as Dr. Levin suggests, to consult the *Directory of Medical Specialists*? Furthermore, good performance is not always synonymous with extent of training and length of credentials. There remain the intangible yet crucial elements of judgment, compassion and ethical commitment. Unfortunately, no directory gives information about the surgeon suffering from Bard-Parkeritis, the practitioner who "keeps 'em coming back," or the university doctor who shunts to the resident excessive responsibility with inadequate supervision.

The problem lies not so much in the pages of this volume as in the system of medical care in this country. As Dr. Levin has written, hopefully some day this type of book will become unnecessary — when and if some of the much-needed reforms he ably discusses are instituted.

That the written word, such as *Talk Back to Your Doctor* can make a difference, those of us who write must continue to believe. My queries and observations, perhaps too cynical and too harsh, should not obscure this book's potential value to medical consumers (which we all are), who should be strongly encouraged to read it.

Robert M. Goldwyn '56
Associate Clinical Professor of Surgery



Letters

Responding to Dr. Ebert

Many seem to feel that the Alumni Survey Committee should have been given a chance for rebuttal of Dr. Ebert's response to our report in the July/August issue. In part, our report had dealt with student dissatisfactions and more specifically, the seeming lack of exciting or worthwhile teaching programs in family practice and community medicine at the Medical School. Dr. Ebert had responded, in part, by arguing that, on the contrary, Harvard had developed the much envied Harvard Community Health Plan and such models as the Beth Israel Ambulatory Center.

Our committee will certainly admit to these and even that there are a few good residency training programs in ambulatory care. However, the charge we developed concerned the paucity of such programs and electives for students. Third and fourth year students still can only elect programs in ambulatory or community medicine that either are university hospital outpatient based — exposing them most often to rather esoteric diseases in a special setting — or they can “develop their own” elective with local practicing M.D.'s. These latter are often happy experiences but only occasionally educational. Rarely have students worked in the Harvard Community Health Plan itself, though we understand this opportunity is increasing now. Once again, when one inquires further, there seems to be only one small office at the whole Medical School where any kind of plans are carried out for coordinating primary health care exposure for students.

Though certainly not blaming Dr. Ebert for what still seem to be gross deficiencies in primary health care exposure for students, we feel the charge has not been defused. It must continue to be of major concern to the whole Harvard community, and the dean must get full and enthusiastic support from all quarters, which we felt was certainly not so when we studied the problem.

William D. Cochran '52

Comparisons

The July/August 1976 *Bulletin* was excellent. However, I would like to comment on the “Davis” affair. The only fault I could find with Dr. Davis's article in the *New England Journal of Medicine* [May 13, 1976] was his lack of sensitivity toward the problem he exposed, and his inability to foresee that his reflections would be misunderstood. No one could really fault him for being in favor of excellence at Harvard Medical School.

I am less charitable toward his critics, from whom I would have expected more objectivity. Their arguments remind me more of the United Nations' polemics than of a reasoned discussion in a university. The condemnatory remarks by Dr. A. F. Poussaint are unforgivable. Dr. Davis has apologized for causing a misunderstanding. Dr. Poussaint owes a similar apology to all of us who cherish the principle of academic freedom.

From a color-blind alumnus
Walter Pick '42

I agree with Dr. Pick that both Dr. Davis and I are entitled to freedom of speech.
— Alvin F. Poussaint, M.D., Associate Dean for Student Affairs

In the aftermath of the commotion surrounding Dr. Bernard Davis's comments on HMS's minority recruitment program, let me offer this sobering observation. A quick review of your Class of '76 internship list reveals that students with Italian or Irish surnames total less than five per cent of the class! I wonder how this compares to national averages, Boston figures, populations cared for in Harvard's teaching hospitals, or more significantly, to the pool of applicants for that Class of '76 four years ago?

Certainly such poor representation of these and other “white minorities” no longer reflects conscious discrimina-

tion, but it makes one wonder who's being squeezed out in HMS's efforts to get the more fashionable minorities on their rolls.

Stephen R. Fahey '75

I do not have available the figures requested by Dr. Fahey. It should be possible to determine the percentages of applicants with Italian or Irish surnames in the pool of candidates for admission to the Class of 1976 and to compare these figures to the percentages of students with Italian or Irish surnames in the class that actually matriculated in September 1972. This will be done, and the figures published in a future number of the Bulletin.

The Faculty of Medicine and the student body of Harvard Medical School have expressed concern over the special problems facing applicants drawn from socioeconomically disadvantaged groups other than the traditional minority ones. Dean Ebert has appointed a faculty-student committee to study the problem in order to define it and to make recommendations for the consideration of the Faculty of Medicine. The co-chairmen of the committee are William V. McDermott, Jr. '42, the Cheever Professor of Surgery; and Julius B. Richmond, M.D., chairman of the department of preventive medicine. — F. Sargent Cheever '36, Director of Admission

A token of esteem

It is always a pleasure to help the Harvard Medical Alumni Association, not in small part due to the excellence of its *Alumni Bulletin*, which is one of my favorite journals, gratuitous as it may be.

The enclosed is, I hope, a small token of my continued esteem for the *Bulletin* and may help in some small measure toward its continued excellence.

William B. Chamberlin, Jr. '38

Our "pride of emeriti/ae"

To have been chosen from among the retired faculty members of the Medical School to be discussed in the *Alumni Bulletin* is a great honor for me and I want to express my sincere appreciation. I have the greatest regard for the company in which I find myself and I liked Dr. Gifford's article very much indeed. His slight reticence met mine harmoniously halfway.

Grete Bibring, M.D.

This letter was received by the Alumni Bulletin's editor, Dr. George S. Richardson, who was responsible for the article on Dr. Rock in the May/June issue.

Though I deplore the publicity you accorded me in the last issue of the *Bulletin*, I am delighted with the detailed reminder of that joyful evening with you at the Laurentian Conference. What a pity that liquor, which has such pleasurable compensations should, in general, be so dangerous! How did you ever remember that sad honeymoon couple suspended on an imperforate hymen? Be pleased to learn that I referred them to Dr. Philpot in Montreal who informed me that he easily opened the way for them.

John Rock '18

I share your pride in your pride of emeriti/ae. I have known and admired them all for many years. Only John Rock's emeritus status anticipated mine, which was 1958.

Though no longer active in the laboratory myself, I maintain an active interest in medical school teaching and research, with special concern for historical aspects. A recent trip took me to the celebration of the founding of the Rockefeller University (née Institute) seventy-five years ago in New York, followed by a visit to my former colleagues in the department of biological chemistry in Boston, then to London for a symposium to honor Sir Ernst Chain, Nobel Laureate of penicillin fame.

A. Baird Hastings

You have not only tried, but succeeded superbly with your *Pride of Emeriti/ae* issue. Congratulations, even if my enthusiasm about your nine examples is colored by finding two good friends among these mentors, and by my own approaching senile status.

Stephen Fleck '40

In the recent article "Herrman Blumgart '21" by Drs. Freedberg and Hamolsky (*HMAB* May/June, 1976), I am quoted accurately, but am incorrectly identified as the president of HMS '65 during the year 1963-64. (I believe this same mistake was printed in the issue of *HMAB* in which Dr. Blumgart's 1963 Gay Lecture was originally published.) I was merely the chairman of the committee (I think it was called the Faculty-Student Committee) which sponsored the George W. Gay lecture. The class president was Bill Clark, and I would hardly want to unsettle (or unseat) him.

The article on Dr. Blumgart was excellent, as was the entire issue on "A Pride of Emeriti/ae." As I read it, and began to think about the impact of HMS on medicine in general, I wondered if it might not be appropriate and instructive to prepare a similar issue on experiences of HMS graduates of the last three or four decades who have dedicated themselves thoroughly to private, non-academic practice. Judging from recent conversations with several of my classmates who have devoted themselves one hundred per cent to patient care, I think the preparation of such an issue would appeal to a wide group of authors and readers.

Michael M. Stewart '65

Drug regulation — a bitter pill?

Dr. Greenblatt's review [*HMAB* May/June 1976] of Dr. Burack's book tries to dismiss not only Dr. Burack's "inflammatory rhetoric" but also the issues that called it forth. Knocking over a series of straw men, however, is hardly an intellectually respectable argument. If serious adverse drug effects are less than a "rampaging plague" does that mean

they can be disregarded? If local pharmacists fail to pass on generic savings to their customers does that mean that physicians should give up trying to save their patients money?

The effort to stigmatize Dr. Burack's writing as "rhetoric" is slightly ludicrous, in view of Dr. Greenblatt's own commitment to rhetorical artifice. For example, he uses the "myth-fact" format to discredit protection of the public by the FDA as "myth" while confirming the opinions of Dr. Wardell as "fact." There is also an implication that each "fact" refutes the preceding "myth," an implication which the literal-minded reader will easily disconfirm. In short, Dr. Greenblatt seeks to counter Dr. Burack's "inflammatory" rhetoric with subtle and diversionary rhetoric of his own.

Nor is Dr. Greenblatt's logic any more respectable than his rhetoric. Attempting to disprove the "myth" that the pharmaceutical industry is to blame for "the perpetuation of misleading information about [drugs]," he argues that industry is not to blame for what is "intrinsic to the [private enterprise] system." The absurdity is exposed when we write out the unstated essential link in this proof: that perpetuation of misleading drug information is intrinsic to the private enterprise system.

Dr. Greenblatt seems to be shutting his eyes to the fact that the FDA and consumerists moved into a vacuum created by the failure of our profession to act effectively against flagrant abuses, including false and misleading promotion and fraudulent drug testing. There is still no medical authority which will do this job — in fact the AMA has moved in the opposite direction by abolishing the independent Council on Drugs. It scarcely becomes this profession to complain about federal bureaucrats and inflammatory rhetoric, seeing that only the profession itself could provide an alternative. Dr. Greenblatt's own abdication of responsibility is explicit (if not quite idiomatic): "the American public is ultimately responsible for such activities that are intrinsic to the system." In a similar vein, the editor of the *New England Journal* has declared that advertising which contains "suggestive statements, implications that go beyond what is really said, and illustrations that exaggerate" meets

Journal standards; and he has declined to publish criticism of those standards. (Ingelfinger, F. J., personal communications, March 24 and 31, 1972) Is it any wonder that the public has turned elsewhere for protection?

If the medical profession wants to be accorded once again the public confidence that would free it from the interference of bureaucrats and activists, I can make two concrete suggestions:

1. Re-establish the independent Council on Drugs with a budget sufficient to let it provide complete and up-to-date guides to drugs and therapeutics.
2. Establish standards for drug advertising and promotion that cut out all the irrational appeals that everyone but the medical leadership can see are flagrantly inappropriate.

These are "realistic" solutions in that there is little likelihood that a thinking public will ever again place much confidence in the medical profession until these two steps are taken; but they are probably unrealistic solutions in that there is little likelihood of their happening in the near future. The only "realistic" solution, then, is for the medical profession to learn to live with the FDA and Dr. Burack until such time as it is ready to resume the burden of responsibility which it has laid aside.

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Hygiene and morality

I applaud Harry L. Mueller '34 for his letter on "Causes of Vanderbilt Disrepair." There are many of us who share his feelings and I believe we should express them and work to eliminate this blight on our school and its facilities.

In this same issue of the *Bulletin* (May/June '76) John Brooks writes "Carl Walter '32: '... a crusade against sepsis in the operating room.' " This fine article might well be recommended as basic reading for all medical students and all of their teachers! It is not recommended as a speed reading exercise. It should be read to be remembered.

All of us should do our part in the return to sanity in controlling and if possible eliminating sepsis by our example. The best orderly in the operating room should be the chief surgeon. He should not hesitate to assist in keeping high standards by the personal virtues of courtesy, cleanliness and a sincere concern for the feelings and actions of others. An equally high standard of morality for himself, his family and associates will do more for a return of a high respect for the profession than any rigid rules of conduct just limited to the time on duty. These standards should prevail in our "off duty" time as well. I do not believe we can live and work a double standard and maintain excellence in either field. Both will suffer.

The basic principles of cleanliness in the operating room naturally extend to all of our activities and to our personal lives — on and off duty. I believe there is still a place for ladies and gentlemen. There should be equality where they are equal; but I also applaud our differences and find pleasure in treating ladies as such and my colleagues as gentlemen, when they are gentlemen.

I find no art or redeeming value in rudeness, vulgarity and obscenities which some seem to take as a badge of their broadmindedness. Let us call things as they are and admit that the high rate of increase in venereal disease is a direct result of those things which we allow to exist by silently condoning promiscuity and filth. We all know that these diseases are transferred from one who has it to one who does not and it is a non-hygienic transfer of a culture of organisms from a basically filthy individual to one who may be clean. This is most often by sexual activity and it is very unlikely to be innocently acquired — although it does happen. Those concerned in this will say that "just a shot will cure me" and so the epidemic spreads.

What do we do about it? Say nothing about its cause or prevention, but establish centers for easy treatment and very rarely put the emphasis where it belongs: on prevention. This trend will not reverse until the values of good morals, cleanliness and closer family relationships are restored to the respect they deserve.

The major force to restore such values lies in the personal actions of the women and men who can see the devaluation of the individual and of human life as it is expressed by the existence of promiscuity, homosexuality, prostitution and their attendant ills. I do not believe we need to build monuments to these ills; but to work at their prevention and try to relieve their causes and treat those afflicted as any other with a disease and without granting special privileges.

We have in our hands the cure for these problems, so let's prevent their spread and finally eliminate them as we know they can be.

Otto E. Aufranc '34

As a four year resident of Vanderbilt Hall (1971-75) and as a recent HMS alumnus, I disagree with Dr. Mueller's statement (May/June '76, p. 40) that student abuse is responsible for the deterioration of Vanderbilt Hall. While I lived there, the students did their best to make the rooms, halls and common areas pleasant.

Dr. Mueller's comments on the students' hygiene and morals are so fantastic that they don't need refuting. I am sorry Dr. Dunphy forwarded to the *Bulletin* what seems to have been a personal letter, and I am amazed that the *Bulletin* printed such an insulting, and personal, expression of disgust. The student-faculty relations at Harvard Medical School must indeed be poor, when, within two months, students are called unqualified, and then filthy and degraded. And one must wonder, why are alumni in the faculty doing the name-calling?

José G. Rigau '75

